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CONNECTIVE-TISSUE NAEVI

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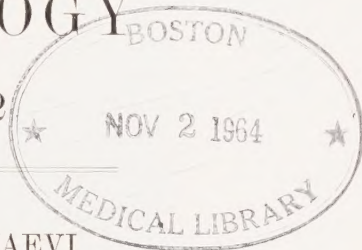
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INTRODUCTION.

THE condition for which the name connective-tissue naevus seems appropriate was first described by Lewandowsky in 1921 as naevus elasticus regionis mammariae. In his three cases the affection was localized to one side of the chest and consisted of numerous slightly elevated yellowish spots, the size of a pinhead or a hempseed, some of which were pierced by a lanugo hair. Histological examination showed changes in the elastic tissue. Some of the elastic fibres were split up and there were homogeneous masses staining deeply with orcein; the normal elastic fibres along the epidermo-dermal junction and in the papillae had disappeared. The collagen appeared normal, and there was an augmentation of muscle-fibres.

In 1922 Lipschütz described four cases which showed a striking clinical resemblance to Lewandowsky's cases; two of them were studied histologically. The elastic tissue was found to be normal, but in the middle and deeper layers of the corium the collagen bundles were hypertrophic, swollen and homogeneous; they stained a deeper red with eosin than normal connective tissue. Lipschütz, probably struck by the resemblance of the patches of irregularly-shaped lesions, lying closely together but not coalescing, to a "crazy pavement," coined the name *pflastersteinförmiger Bindegewebsnaevus*.

Since Lewandowsky's and Lipschütz's publications a good many similar cases have been reported; the total in the literature available to me amounts to 48. Sometimes changes in the elastic tissue, as described by Lewandowsky,



predominated, while in other cases the elastic fibres appeared normal, but a coarsening and homogenization of the collagen bundles, as in Lipschütz's cases, was recorded. Often changes of the elastic tissue and of the collagen went together. Hyperplasia of muscle fibres is sometimes mentioned, and in one case (Talaloff, 1930) hyperplasia of sebaceous glands. The name connective-tissue naevus (*Bindegewebsnaevus* or *Bindegewebsorgannaevus* Gutmann, 1925, 1926, 1927) is used by most authors. The vast majority of cases were published by German authors, for the greater part only in short reports in society transactions. In the French literature With and Kissmeyer (1922) described as *dystrophie élastique folliculaire* a Scandinavian patient whom they had presented in 1918 and 1919 as *naevus sclérodermique folliculaire*; Montpellier and Lacroix (1923) reported a case which they misinterpreted as colloid (pseudo) milium and named *naevus pseudocolloide périfolliculaire*. I found one dubious English case (Twiston Davies, 1930), one Italian (Rita Leone, 1937), one Swiss (Lutz, 1935) and four Russian (Talaloff, 1930) cases. In all probability the juvenile elastoma described by Weidman, Anderson and Ayres (1933) belongs to the same group, and it seems to be the only American case. The remaining publications are by German and Austrian authors.

The clinical picture may be sketched as follows: The smooth, white or yellow, flat, slightly elevated and somewhat indurated lesions vary in size from a pinhead to half a centimetre or more in diameter. In some cases there is a tendency to perifollicular localization. The lesions are grouped together to form one or more patches of varying size, which in most cases are localized asymmetrically, sometimes more or less zoniform. In rare cases large areas of the body surface are involved. Many of the authors who wrote about connective-tissue naevi reported several cases; this may indicate that the condition is not so rare as it would appear from the scarcity of published case-reports. Probably it is often overlooked.

CASE REPORTS.

CASE I.—An 8 year-old girl, was sent from the out-patient department of the paediatric clinic (Prof. Dr. S. van Creveld), which she visited for some minor complaints. The results of internal examination were essentially negative.

In the left scapular and lumbar regions, on the left buttock and the right hip were groups of flat, slightly elevated, smooth lesions (Fig. 1). Most of the lesions were about half a centimetre across but some were much smaller. Their colour was yellowish, like old ivory. A perifollicular arrangement was not in evidence.

Histology.—On 23.xii.50 a biopsy was made from the left buttock. With haematoxylin-eosin the surface is undulated and there is slight hyperkeratosis, especially where the surface is sunken in. The stratum granulosum is present everywhere but narrow. In the prickle-cell layer there are groups of hydropic cells but the basal layer is normal.

In the corium the structure of the connective tissue is coarsened. The collagen bundles are stained a deep red with eosin, and for the greater part they appear to be cut transversely. Many bundles show no fibrillar structure, but are homogeneous and give the impression of being swollen. The bundles are separated by wide spaces.

Smooth muscle fibres are abundant, but no hair follicles, sebaceous glands or coil glands are present in these sections.

Van Gieson shows some of the details mentioned even more clearly, the collagen staining a dark red.

Staining with acid orcein (Unna-Tänzer) (Fig. 2) shows normal elastic tissue in the papillary and subpapillary layers of the corium. Slender, well-coloured fibres ascend in the papillae and run along the epidermis. In the deeper layers of the corium the orceinophil tissue has increased. There are many black-staining, uneven, coarse fibres and irregular clumps in which no fibrillar structure can be seen.

Von Kossa staining for calcium was entirely negative.



FIG. 1.

Silver impregnation (Laguesse) (Fig. 3) shows normal reticulum fibres in the papillary layer; the reticulum of argyrophil fibres along the epidermo-dermal junction is clearly visible. In the subpapillary layer a network of reticulum fibres is present only in some places, while in the deeper layers of the corium it only surrounds vessels and glands. Many coarse bundles are stained partly red, partly black; in some cases distinct black-staining fibres can be seen in these bundles, but in others no fibrillar structure is visible, or there are only short black lines and dots suggesting fibres that have been cut transversely. There are some coarse bundles which have stained a homogeneous black.

In sections stained with toluidin blue only a few mast cells are seen. Staining with cresyl-echt-violet and with Sudan III did not show further details.

CASE 2.—An 8-months-old girl was admitted to the paediatric department, where I saw her in consultation. The child's parents were healthy and the birth had been

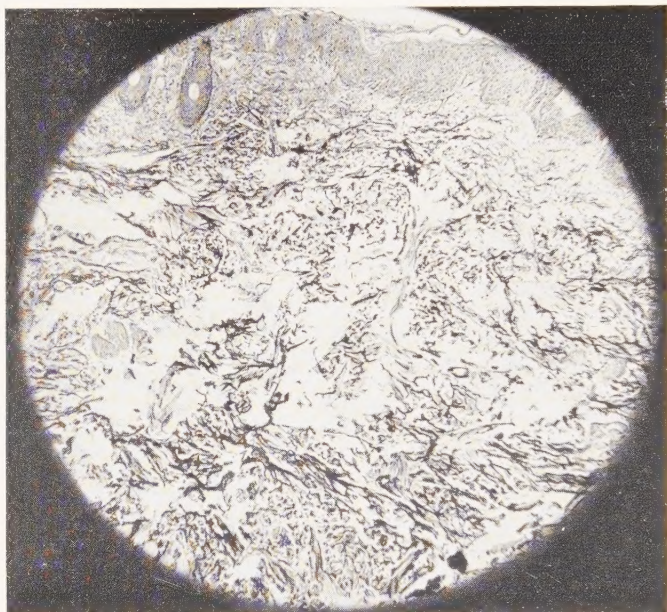


FIG. 2.

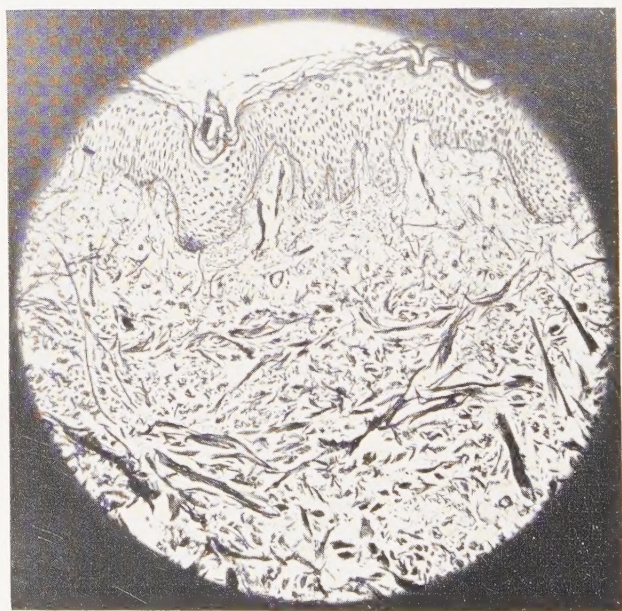


FIG. 3.



FIG. 4.

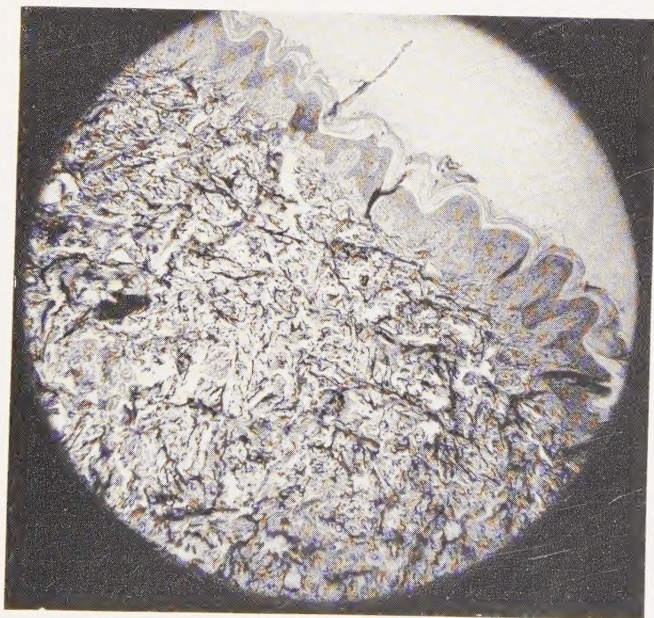


FIG. 5.

normal. She showed a marked microcephaly, for at the age of 6 months the circumference of the skull was 30.5 cm., the fontanelle had not closed and the skiagram showed open sutures with no calcification. The right ear was malformed and the palatal arch high, the neck very short, the nose flat and broad. The muscles, especially of the legs, were hypertonic. A chorioiditis existed in both eyes and there was convergent strabismus. Apparently the child was an imbecile. Wassermann and Kahn tests were negative; von Pirquet negative.

Cultures from a biopsy from the skin (Prof. Dr. W. Kouwenaar) and neutralization tests (Sabin) for toxoplasmosis were negative.

The skin of the extensor surface of the extremities, the abdomen and the greater part of the back shows numerous flat, very slightly elevated, somewhat indurated, ivory-coloured spots, much varying in size (Fig. 4). On the extremities they are more or less round, on the trunk mostly oblong.

Histology.—On 11. xi. 48 a biopsy was made from the epigastrium and on 15. xii. 48 from the dorsum of a foot.

In sections stained with haematoxylin-eosin no distinct pathological changes are found. Perhaps there is some augmentation of connective-tissue nuclei in some places, especially in the superficial layers of the corium, but the difference from normal is certainly very slight.

Van Gieson staining shows no more pathological details; in one small area the collagen has stained a very deep red and looks homogeneous, but this is around a fissure in the section and probably of no significance.

Staining with acid orcein (Unna-Tänzer) (Fig. 5) shows normal elastic fibres in the papillary and subpapillary layers of the corium. In the deeper layers definite pathological changes are present. Here are many coarse, uneven, sometimes very thick undulating fibres, staining black with orcein. Also there are many irregular, black staining masses which do not show a fibrillar structure.

Von Kossa staining does not show calcium deposits.

COMMENT.

Both children show a clinical picture which is typical of connective-tissue naevus. In the second case an unusually large part of the skin is involved. Histological study has confirmed the diagnosis. The histological changes in the second case closely resemble those first described by Lewandowsky, while the first case is of the mixed type. As has been expressed by several authors (Gutmann, 1927; Boehm, 1930; Blaich, 1947), connective-tissue naevi result from a faulty development of the mesenchyme in which the collagen, elastic tissue as well as smooth muscle fibres may participate in a varying degree. This explains the differences in the histological picture—which are not of primary importance—and the name “connective-tissue naevus” covers the different types satisfactorily. Of course the term “naevus” is used here in the old clinical sense as defined by Unna and others. Perhaps it would be better to reserve the name for tumours in which naevus cells can be demonstrated but one must accept its current use to indicate benign slowly growing tumours of the skin resulting from faulty embryonal development.

In considering the histological differences in connective-tissue naevi we touch another problem—the impossibility of distinguishing with certainty

between collagen and elastic tissue by the staining properties of the fibres. It is highly probable that collagen may, by unknown physical or chemical changes, acquire the property of staining black with acid orcein. In certain cases it is impossible to say whether coarse bundles, staining black with orcein, are collagen bundles which have been tinctorially changed or elastic tissue of which the structure has been altered. It seems likely that the conduct towards certain stains may be more easily altered than the structure. This problem has been thoroughly discussed by Percival, Hannay and Duthie (1949) in connection with senile degeneration of the skin (senile elastosis). Hannay (1951) used the same arguments when he advanced his interesting theory that in pseudoxanthoma elasticum the material staining black with orcein is not structurally altered elastin but tinctorially changed collagen. In connective-tissue naevi changes of the collagen are evident in many cases (e.g., my Case 1). It is certain that the elastic tissue may be altered also and rarefaction or local absence of elastic fibres are reported by several authors. On the other hand it is possible that the coarse fibres and irregular clumped masses staining with orcein in my two cases and in many others are not elastic tissue but are the products of degenerative changes in collagen.

The results of Laguesse reticulin staining in my first case may be explained in the same way. A network of reticulin fibres is missing in the greater part of the lesion. The coarse, black-staining bundles are probably collagen which by some unknown change has become argyrophil. Sachs (1918, 1926) attributed the yellowish colour of connective-tissue naevi to physical changes in the collagen.

Connective-tissue naevi present a picture that has some features in common with pseudoxanthoma elasticum; Lewandowsky discussed the relation between the two conditions, but because of the asymmetry, the different localization, the larger lesions and the localization of the elastic tissue changes in the more superficial layers of the corium he felt justified in setting his cases apart. With and Kissmeyer, Gutmann, Boehm and Blaich also pointed to a close relation between connective-tissue naevi and pseudoxanthoma elasticum, and Boehm included pseudoxanthoma elasticum in Gutmann's *Bindegewebsorgan-naevus*. Weidman, Anderson and Ayres thought it possible that their case of juvenile elastoma, which in all probability belongs to the connective-tissue naevi, would develop into pseudoxanthoma elasticum, and Ormsby and Montgomery (1948) reproduce this opinion in their textbook.

Without doubt pseudoxanthoma elasticum and connective-tissue naevi have much in common; in both the yellowish colour results from changes in the connective tissue of the corium and the resemblance between the histological picture in the two conditions is striking. Still, there seem to be enough differences to separate the two diseases. The principal differences are summarized in a table.

Pseudoxanthoma elasticum.

Predilection for the sides of the neck,
the armpits and groins.

Symmetrical as a rule.

No connection with hair follicles.

Small lesions, forming a network.

Often combination with vascular and
ocular lesions (angioid streaks).

Always changes in the tissue staining
with orcein.

Calcium deposits in the fibres staining
with orcein.

Connective-tissue naevi.

Localization on almost any part of the
body.

Often asymmetrical.

Lesions sometimes perifollicular.

In most cases larger lesions suggesting
"crazy pavement."

Changes limited to the skin (as far as
we know).

Sometimes changes in the tissue stain-
ing with orcein.

Calcium deposits not demonstrated.

The connective-tissue naevi form a rather well-defined entity. From fibromas they can easily be separated clinically, and the absence of elastic fibres in fibromas offers an important histological difference.

More difficult is the separation from the "chagrin skin" in Pringle-Bourneville's disease. The somewhat elevated patches with a normal, yellowish or slightly bluish colour and a grooved surface, resembling chagrin leather, which occur in about half of the cases of adenoma sebaceum differ from many of the yellowish-white smooth connective-tissue naevi *sensu strictiori*. However, they may also be considered as naevi developing from the connective tissue of the corium. Riehl (cited by Sachs) and several other authors have used the name connective-tissue naevus for the "chagrin skin" in adenoma sebaceum patients. The histopathology of adenoma sebaceum has been the subject of many thorough investigations, but reports on the histology of "chagrin skin" are rather scarce. Feriz (1930) described hyperplastic connective tissue with augmentation and thickening of collagen bundles with few nuclei; in this area elastic fibres were missing. Carol and van Heusden (1937) described coarse undulating collagen bundles, separated by wide spaces, small infiltrates formed by round cells and a few leucocytes, many sebaceous glands and some cysts. Elastic tissue was almost absent in the papillary layer, while in the deeper layers it was irregular and showed clumping. Twiston Davies (1930) reported broken and swollen acidophil collagen fibres and the absence of elastic tissue. Kitamura, Kanehiko and Raizo-Yoshizaki (1939) described hyperplasia and homogenization of collagen bundles and a decrease and splitting up of elastic fibres, in the presence of many smooth muscle bundles. Carol pointed to the similarity in structure between the lesions of adenoma sebaceum and "chagrin skin," the differences (e.g., less sebaceous glands in the latter) being explained by the different localization; both lesions are hamartomas. Several authors have placed the connective-tissue naevi in Albrecht's group of hamartomas. The resemblance between the histological changes in "chagrin skin" and connective-tissue naevi certainly is striking.

It seems logical to include the "chagrin skin" of Pringle-Bourneville's disease in the group of connective-tissue naevi. If we accept this standpoint the total number of published cases of connective-tissue naevi is considerably higher than is stated in the beginning of this article. Nevertheless, by its occurrence together with the manifold symptoms of Pringle-Bourneville's disease and in many cases also by its clinical appearance, "chagrin skin" constitutes a definite variety. In Pringle-Bourneville's disease many kinds of congenital malformation besides adenoma sebaceum and tuberosa sclerosis are well known. It is interesting that my second patient presented also a combination of different congenital malformations, including connective-tissue naevi and a cerebral anomaly (microcephalia), although the clinical picture differed very much from Pringle-Bourneville's disease.

SUMMARY

The literature on connective-tissue naevi is reviewed. Two cases are reported and the histological changes are discussed. It is concluded that the condition is distinct from pseudoxanthoma elasticum, although the diseases are related.

The so-called "chagrin skin" which often occurs in patients with adenoma sebaceum (Pringle-Bourneville's disease) constitutes a variety of connective-tissue nevus.

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MULTIPLE SUPERFICIAL BENIGN BASAL-CELL EPITHELIOMA OF THE SKIN.

REPORT OF A CASE WITH ZOSTERIFORM ARRANGEMENT OF
LESIONS AND SATISFACTORY RESPONSE TO TREATMENT
WITH THORIUM X.

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IN 1928 the late Dr. Fred Wise presented a paper on "Multiple Superficial Benign Epithelioma of the Skin" before the Section on Dermatology and Syphilology of the American Medical Association. This excellent and comprehensive treatise has come to be considered as one of the outstanding articles on this subject in medical literature (Wise, 1929). Terminology, clinical features, differential diagnosis, histopathology and theories of origin are further discussed in papers by E. Graham Little (1923), Hamilton Montgomery (1929), J. Dörffel (1935) and Arne Madsen (1941), as well as in the standard dermatological text-books.

The following case is being reported for two reasons: firstly, because, as far as we have been able to ascertain, this is the first case of multiple superficial benign basal-cell epithelioma to be reported in which there is a zosteriform arrangement of the lesions (MacKee, 1932); and secondly, because of the excellent therapeutic results following the topical application of thorium x.

CASE HISTORY.

C. S —, a 49-year-old white male, born in New York City and a lawyer by occupation, was first seen by us on 17 November 1947. The patient presented himself for follow-up and treatment of numerous superficial benign basal-cell epitheliomas for which he previously had had regular and competent dermatological care.

Family history.—Irrelevant. There was no other discoverable case of benign superficial basal-cell epithelioma or of other epitheliomas in the patient's family.

Previous history.—Shortly after birth the patient's skin "was covered with small white blisters" which cleared in several days without treatment.

The patient had most of the usual childhood diseases. He denies having had any operations or known trauma to the spine or vertebral area or to tissues now affected with skin lesions.

At the age of 17 the patient first noticed a small erythematous area just below the left breast. This lesion slowly grew in size and the dry superficial crust that formed sloughed off from time to time. There was no pain or other associated symptom.

Several years later new lesions developed in the vicinity of the area originally affected. These, as well as can be remembered by the patient, started as papules, some of which enlarged to form patches of various sizes. As time passed new lesions formed on the left anterior chest and left side of the back which were arranged in roughly linear and arciform fashion, as though they were following the course of an intercostal nerve. The affected areas soon became a source of irritation, with burning and occasionally sharp non-radiating pain of short duration.

Treatment was started in 1926. At that time a series of eight superficial x-ray treatments, given to the affected areas at monthly intervals, resulted in a temporary arrest of the process. Approximately one year later blistering doses with the Kromayer lamp were given once a month for a total of twelve treatments. Subsequently the old lesions increased in size and new ones developed more rapidly than before. Six intravenous injections of gold sodium thiosulphate and a series of "powder treatments" by a homoeopathic physician were of no value.

New lesions continued to appear and in January 1932 the patient consulted Dr. George M. MacKee. A clinical diagnosis of "epithelioma, basal-cell, multiple lesions in zosteriform arrangement" was made. A specimen removed from the lateral left chest wall on 19 January 1932 was reported by the histopathology section of the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital* as follows:

"There are a number of buds of varying size projecting into the cutis. In the central portion of the lesion the epidermis is wanting. That portion of the epidermis that has no projecting buds is relatively thin. The cells of projecting buds are composed of characteristic basal cells. About these cell zones there is a considerable connective-tissue hyperplasia and there are lymphatic spaces between the affected epidermis and the underlying cutis. Throughout the remainder of the upper cutis there is a well-defined exudative inflammatory process. There is no evidence of degeneration." Microscopic diagnosis: "Basal-cell epithelioma—multiple foci."

A second biopsy taken from the sternal area at the same time was reported as follows: "Extending from its attachment to the under-surface of the epidermis down into the midcutis is a tumour mass; in part the central portion is converted into cavities and, in part, it is solid. There is a considerable amount of proliferation of connective tissue and a moderate exudative inflammatory process. The entire tumour mass including its projection is limited by a definite columnar basal-cell layer. No whorls or pearls are seen. Few mitotic figures are seen."

Microscopic diagnosis: "Basal-cell epithelioma *en masse*."

In January of the same year the patient was presented by Dr. MacKee before the New York Dermatological Society as a case entitled "Epitheliomatosis Cutis, Linear Distribution" (MacKee, 1932).

Electrodesiccation was the method selected for the treatment of the active lesions. A number of visits and a total of three hours were needed to desiccate the original lesions, and it is estimated that at least another three to five hours of treatment were given over the years. This modality served to destroy the lesions, but the cosmetic result was poor because of the hypertrophic scarring which followed. Consequently solid carbon dioxide was used in treating the other lesions, which were "benefited in the main."

Present history and clinical description.—When first seen by us in 1947 the patient was found to be in excellent health although a little underweight for his height. There was no history of recent illness, nor could a history of receiving arsenical medications be elicited.

There were numerous lesions arranged in linear (zosteriform) fashion over the left thoracic wall, extending from the xiphoid process, anteriorly, to the level of the

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sixth and seventh thoracic vertebrae, posteriorly (Fig. 1). A few scattered lesions were noted behind the left ear, on the left thigh, and on the left arm, as well as on the upper and lower parts of the back.

The lesions were in various stages of development from the early flat shiny macules and slightly indurated papules to the older red and violaceous discoid patches, which were either level with or slightly depressed below the surface of the surrounding skin.

The isolated small or early lesions, which were primarily macular or papular, were surrounded by apparently normal skin. Many of these coalesced to form round, oval and polycyclic plaques. Some of these early lesions were small (glass pin-head sized) pink, pearly nodules, which on inspection often revealed the presence of minute superficial vessels easily seen through the thinned epidermis. Other lesions presented a delicately rolled, waxy-looking barely palpable border. They



FIG. 1.

ranged from a few millimeters to an inch in size and in some areas were grouped to form patches the size of a man's palm. Moderately adherent scaling was found on some, while others were crusted in the centre with an encircling glistening reddish or violaceous zone.

Numerous scarred areas were present, some of which were soft and pliable, although the majority were hypertrophic and less flexible. Other lesions were present which had combined features of those described above. Some of the lesions resembled those of a chronic dry eczema, while others looked like psoriasis or Bowen's disease. Many of the lesions were in a comparatively orderly and linear arrangement.

Histology.—A biopsy taken from a lesion in the left mid-back area and examined by Dr. Charles F. Sims* on 22 November 1947 was reported as follows:

“The epidermis is irregular with, for the most part, flattened rete pegs. There are small masses of basal cells of varying size arising at several points along the basal-cell layer. These masses are well defined, irregular, lined by a columnar margin of basal

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cells, and extend a short distance into the upper corium. The superficial vessels are dilated and the surrounding connective-tissue framework is oedematous. A sparse, non-specific, diffuse, cellular infiltration is present in the upper corium.

"Diagnosis: Multicentric basal-cell epithelioma."

The following is the report of a neurological examination performed by Dr. S. Bernard Wortis* on 20 April 1950:

"Neurological examination of this man was entirely normal as regards cranial nerves, motor power, co-ordination, reflexes and sensation. The skin lesions he has tend to have a dermatomeric root distribution over thoracic 6 and 7, along thoracic 12 and some along lumbar 1 left dermatome. This points to a relationship between the skin lesions and the posterior root areas.

"Psychiatric status is normal as regards this patient's sensorium and intellectual resources."

A radiographic examination of the entire spine by Dr. Milton Friedman† on 5 June 1950 revealed sacro-iliac and hip-joint arthritis and spondyloarthritis of the lumbar vertebrae.

Some of the lesions were treated with podophyllin several times (Smith and Garrett, 1950; Hall, 1950), following which there was still clinical evidence of activity. This treatment was discontinued in favour of the better results obtained with thorium x, which was being tried concomitantly on other areas.

Treatment with thorium x.—We decided to use thorium x on our case in May 1949 following the satisfactory results observed after the use of an alcoholic solution of this radioactive material in the treatment of basal-cell epitheliomas as employed in the physiotherapy section of the Skin and Cancer Unit of the University Hospital and New York University Post-Graduate Medical School (Sher and Howes, 1951; Jessner, Kleine and Sher).

Thorium x had been used previously by Prosser Thomas (1939), Lomholt (1936) and Jessner (1951) in the treatment of epitheliomata as well as many other dermatological conditions. In fact, Prosser Thomas in reporting his results in the treatment of basal-cell epitheliomata stated that several cases of the flat, superficial, cicatrizing type in which more than one lesion was present were apparently cured. Jessner, in a personal communication, claims he had excellent results in treating multiple superficial basal-cell epitheliomata with thorium x in an ointment in the early part of this century.

Thorium x was used in alcoholic solution in a concentration of 300 microcuries per ml. (2000 electrostatic units per c.c.). The lesions to be treated were first cleansed well with acetone or ether in order to remove the fatty film and superficial scale and debris. Loosely adherent crusts were removed and, whereas when this method was first used we made an effort to remove even the most firmly attached crusts, we have since abandoned such a vigorous approach. Removal of the more firmly attached crusts was tedious, painful to the patients, and often resulted in serous oozing and bleeding which delayed the application of the thorium x solution. Nevertheless, where the crust is part of the active and growing lesion, it is necessary that it be removed in order to obtain the best results.

The prepared area was now ready for the application of the thorium x solution. An applicator stick with a fine wisp of cotton-wool at its tip was moistened with the solution and was rubbed on the lesion, including a surrounding zone of 5 mm. Moderately firm pressure was exerted on the applicator and a circular motion proved the best and easiest to control. Following each application the area was allowed to dry and the application was repeated. This routine was followed five times in

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immediate succession. Finally, each area was covered with flexible collodion, which hardened in place to form a protective covering. This transparent dressing and shield was usually left in place until the following week, when it was removed with acetone or by peeling it off. After a thorough cleansing the area was generally ready for another treatment with thorium x solution. Occasionally serous or seropurulent material collected under the collodion and necessitated drainage or wet compresses. Treatments were repeated at weekly intervals for a total of three applications. To date this has been sufficient for the satisfactory treatment of the majority of the lesions. The few lesions which failed to respond to this course were treated again at later dates during the subsequent seven months. A few lesions received as many as two or three courses (six to nine treatments).



FIG. 2.

When the treated areas were observed one week after the first application of thorium x there was marked erythema, limited to the painted area. With each succeeding treatment the areas became darker in colour to the point of becoming a very dusky red. This was followed by pigmentation (reddish-brown to brown), which persisted in most cases for two to four months. Areas of depigmentation were observed at the site of a few of the treated lesions (superficial atrophy and scarring?). The lesions gradually became flatter and a fine white pliable scar was the end-result (Fig. 2). No epilation was noted in any of the treated areas.

DISCUSSION.

Whereas this particular cancerous dermatosis has not previously been reported as occurring in zoniform arrangement, many other skin diseases have been so described: to name a few, lichen striatus (Senear and Caro, 1941), lichen planus (Davis, 1938), leukaemia cutis (Barney, 1938), naevus anaemicus

(Pace, 1941), xanthoma tuberosum multiplex (Kreibich, 1926), naevus unius lateris (Montgomery, 1901), zosteriform metastasis (Montgomery, 1937), scleroderma (Rubin, 1948), syphilis (Jeanselme, 1927), psoriasis (Woringer, 1936; Russell, 1950) and pigmented naevi (Frank, 1947). In some of the above cases the zosteriform distribution followed an attack of herpes zoster or a nerve injury. Neurologic and roentgenologic examination of our patient failed to reveal any evidence of nerve or bone abnormality which might be considered as contributing to the dermatomeric arrangement of the lesions.

While superficial epitheliomatosis of this type may be treated by many methods, the hypertrophic scarring which followed electrodesiccation in this case and the great number of lesions spread over a large area prompted us to try thorium x. We were very gratified with the excellent response to therapy, and with the patient's statement that this treatment had caused less discomfort and incapacity than any previously used.

Several lesions failed to respond fully to the arbitrarily set course of three treatments with thorium x. These recurrences were easily discovered both by the patient and by us, and the large majority of them responded adequately to a second course of thorium x therapy. Perhaps an increase in the number of applications during each treatment or of the total number of treatments in a course will afford an even more effective approach to the therapy of such epitheliomas. The excellent therapeutic and cosmetic result and the minimum of discomfort during treatment are features which certainly justify further trials with thorium x. This approach, of course, warrants the same careful observation and follow-up that is given after any other form of treatment of precancers or cancers of the skin.

SUMMARY.

A case of multiple superficial benign basal-cell epithelioma is reported with both clinical and histopathological details because (1) it is believed to be the first such case to be presented in which the lesions have a zosteriform arrangement, and (2) of the favourable response of the majority of the lesions to treatment with two to three courses of topically applied thorium x in alcoholic solution.

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SUN HEAT AND ARTIFICIAL HEAT IN RELATION TO SKIN ERUPTIONS DUE TO LOCAL IRRITANTS.

H. G. ADAMSON.

THERE is one important factor in the aetiology of eruptions due to plants or dyes which seems to have been generally overlooked, or its significance disregarded.

It is not one which can be said to help to explain the phenomenon of super-sensitiveness or allergy as the sequence of an initial attack, nor to do away with the desirable investigations and discussions as to the biological mechanism of the allergic state.

It does, however, offer a simple explanation of the cause of the initial attack, and it may be reasonably alleged that it renders unnecessary the hypothesis of an inborn hyper-sensitiveness to a particular irritant, so frequently suggested.

The factor to be here considered is that of exposure to the sun's heat or to an artificial heating coincident with the plant or drug contact when the first attack of dermatitis occurs.

In the case of a plant dermatitis it will be found that it first occurred when the patient's skin came into contact with the offending plant when he or she was exposed to the sun on a particularly hot day, although the person affected may have previously handled the same plant on numerous occasions without ill effect while the weather was milder.

Similarly, in the case of a dermatitis due to a dye or other chemical, the first attack will probably have occurred only when the contact took place near a fire or in a heated room.

Already, in a letter to the *British Journal of Dermatology* for December 1936 the present writer has noted this association of an initial contact dermatitis with exposure to sun or to artificial heat, and has there referred to a paper by the late Dr. Sequeira on "Pyrethrum Dermatitis in Kenya" (1936), in which he stated that "it was noticed that very few cases of dermatitis due to the plant occurred in the winter months, but that in hot weather cases were numerous, and sweating tended to aggravate the condition." One grower who had worked in the fields for many years without any ill effects rapidly developed a generalized eruption.

Numerous incidents might be given of patients who had suffered their first attack of contact dermatitis after exposure to the sun or to artificial heat, as, for example :

(1) That of a young man who had a severe eruption on the face, forearms and hands after varnishing a boat on a hot sunny day, and who had for several years previously carried out a similar operation in milder weather without any harm to his skin.

(2) A lady who had been accustomed to pick off the dead flowers of Canterbury-bell without any ill result, until one year she did so in hot sunshine, with a resulting dermatitis of the hands and, incidentally, with frequent more wide-spread dermatitis on any slight contact with these flowers or even the seeds.

(3) A gardener who had long been used to handling hyacinth bulbs, and who suffered from repeated dermatitis of the hands and face only after a first attack while doing so in a hot sunny greenhouse.

(4) As an example of a dermatitis from a dye, that of a lady who had her first attack after wearing a fur collar in a hot room although she had worn the same for several winters without any harm.

CONCLUSION.

1. That a first attack of dermatitis from contact with a local irritant is usually found to occur when the patient has been exposed at the same time to heat from the sun or to artificial heat.

2. That the patient may have been many times previously in contact with the local irritants without any dermatitis resulting ; which would seem to negative the hypothesis of an *inborn* idiosyncrasy to that particular irritant.

3. That allergic manifestations towards particular local irritants may be acquired by normal persons as the result of an initial dermatitis following a contact in association with exposure to heat of the sun or to artificial heat.

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DRUG ERUPTION FROM PALUDRINE (PROGUANIL) HYDROCHLORIDE: REPORT OF A CASE.

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IN the prevention and treatment of malaria, paludrine (N_1 -*p*-chlorophenyl- N_5 -isopropyl biguanide) is remarkably free from toxicity. Specific allergic sensitivity must be extremely rare, as no case report has yet appeared. Gunther (1951) mentions a man who used to develop mild irritation, with slight redness, at the medial corners of the eyes; on halving his prophylactic dose the trouble disappeared. Fairley (1946) mentioned toxic complications—gastro-intestinal, urinary and haematological—but stated that no example of individual idiosyncrasy had so far been encountered. Findlay (1949, 1951) states that "urticaria has appeared on rare occasions and itching, puffiness of the face and erythema of the face, palms of the hands and soles of the feet. The areas affected by erythema may subsequently exhibit desquamation." I have been able to find no other reference, and believe that a fuller description should be available in dermatological literature.

CASE REPORT.

C. P. L—, male, white, aged 48, complains of $1\frac{1}{2}$ years' recurrent outbreak on hands and feet.

History.—The patient lives in Johannesburg, but his work as consulting engineer entails travelling in many parts of Africa. $1\frac{1}{2}$ years ago, while in Northern Rhodesia, he noticed paraesthesia of the hands and feet which he attributed to intense physical strain. The next day the hands and feet were flushed, swollen and painful. This intense inflammatory reaction lasted for a week and was then accompanied by gross peeling, especially of the palms and soles. The severity of the condition made it impossible to undertake normal activities. The affected parts became normal again after 5 weeks, except for the nails (see later).

The second attack occurred 2 days after arriving in St. Lucia (Zululand) on a fishing holiday and pursued the same course, lasting between 4 and 5 weeks.

The third attack began in an aircraft on the way to Uganda. The paraesthesia was noted while the craft was re-fuelling in Rhodesia and the patient was exposed to extreme heat. This attack, too, lasted between 4 and 5 weeks, and followed precisely the same course as the previous ones.

In view of the above facts the patient assumed that the condition was caused by exposure to heat.

Drug history.—Until $1\frac{1}{2}$ years ago the patient was in the habit of taking mepacrine (atebrin) as a prophylactic during trips to endemic malarial areas. He began taking paludrine at the beginning of the trip to Northern Rhodesia, 100 mg. twice weekly, one week before the onset of his complaint. He took paludrine on only two occasions subsequently—the trips to St. Lucia and Uganda. On each of these occasions the first dose was taken about 36 hours before the onset of the eruption.

Examination.—The patient presented himself during the third week of the third attack. The hands and feet were red and puffy and there was gross desquamation of the palms, soles and adjacent areas. Some of the scales measured 2 in. in width. The underlying skin was thin and tender. The dorsa showed traces of branny desquamation. A deep transverse furrow on every finger- and toenail was evidence of his previous attack. (This furrowing actually occurred with all three attacks, and led to painful breaking of the nails when the furrows approached the free border.) The appearance of the hands and feet was indistinguishable from that seen in severe scarlet fever during the stage of desquamation.

General examination of the patient revealed no further abnormality.

Subsequent course.—No further attack has occurred in a period of 9 months, although the patient has made three more trips to Uganda. On each occasion mepacrine has been taken instead of paludrine.

The patient was asked to take a trial tablet of paludrine while in Johannesburg, but refused in view of the crippling nature of the consequences. He is fully convinced that the eruption was caused by paludrine.

COMMENT.

Even without knowledge of Findlay's passing reference to this clinical picture, paludrine sensitivity was the obvious diagnosis in this case. The onset of the first attack one week after first exposure—the period necessary for sensitivity to develop—and the shorter interval of 36 hours in subsequent attacks are typical. It is regrettable that the patient did not permit reproduction of an attack under controlled conditions, but his reluctance is natural, and this does not invalidate the diagnosis. Other drug eruptions, such as the lichen planus-like exanthem caused by mepacrine, are also recognized without having been voluntarily reproduced.

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ROYAL SOCIETY OF MEDICINE.

SECTION OF DERMATOLOGY.

President—Dr. W. N. GOLDSMITH.

17 May 1951.

Prurigo Nodularis.—Dr. P. D. C. KINMONT.

G. P.—, male, aged 55.

History.—When first seen on 22.ix.48 he had had itchy excoriated papules on the outer sides of the forearms, arms and thighs for several months, and complained of severe itching at night. He was treated with local applications and sedatives. During the next twelve months the papules gradually enlarged to the present pea-to cherry-sized nodules. Nothing has relieved his irritation to any extent.

Examination.—He has dry, raised, scaling and verrucose bluish nodules on the arms, thighs and legs, mainly on the extensor surfaces. The abdomen, loins and back up to the scapular region are also affected. He has mild exophthalmos unassociated with tachycardia, and a chronic bilateral phthisis. There are no lesions in the mouth.

Biopsy (Dr. G. R. Osborn).—Histological section from the arm shows appreciable but nodular thickening of the surface stratified squamous epithelium, the result of notable increase in the stratum corneum, some thickening of the stratum pigmentosum and some acanthosis. In the corium nerve trunks are abundant and the inflammatory reaction is almost confined to these. The inflammatory cells are mostly lymphocytes, but some eosinophil polymorphs occur.

Non-suppurative Panniculitis.—Dr. P. D. C. KINMONT.

Mrs. L. S.—, aged 43.

History.—In August 1950 she noticed swelling on the outer side of right knee, followed by aching in the thigh and the appearance of marble-sized, not tender nodules.

December 1950 the left thigh became affected.

February 1951 the nodules became tender and the overlying skin warm and pink.

General health has always been good except for Raynaud's phenomenon of moderate severity (fingers and toes) for 5-6 years.

No history of previous illness.

Had taken no bromides, iodides, or other drugs.

Examination.—There is a diffuse nodular plaque, adherent to the deeper tissues, in the subcutaneous tissue of each thigh with deep hollows in places. Over the nodules the skin is warm and pink, in the depressions brownish purple. The regional lymph nodes are not enlarged. The skin on the fingers and toes shows no atrophic change.

The nails have been ridged for many years.

The tip of the spleen is palpable.

Systematic examination shows no other abnormalities, and no obvious focus of infection.

Investigations.—E.S.R. has varied between 37 and 51.

13.iii.51: Hb = 90; R.B.C. 4.13; W.B.C. 10,000. Eosinos. 3%, basophils. 1%, polys. 64%, lymphos. 25%, monos 7%.

13.iii.51: Serum proteins—normal.

B.M.R. = +26.3.

W.R. negative.

Liver function tests.—Thymol turbidity and flocculation increased.

Skiagram of chest normal.

Mantoux 1:1000 and 1:100, negative.

Biopsy (Dr. G. R. Osborn).—The epidermis was relatively normal, but melanin pigment was somewhat excessive. In the superficial parts of the corium there was no significant lesion, but around the deeper dermal appendages there was lymphocytic infiltration. The main abnormality was an inflammatory reaction in the subcutaneous fat. There were many lymphocytes, plasma cells and macrophages. Some endarteritis was present. In most parts the inflammation was appreciably heavier in the fibrous strands between fat cells than in the fat itself. The skeletal muscle appeared to be normal. The appearances were compatible with a diagnosis of panniculitis.

Progress.—During the six months in which the patient has been observed the plaques have slowly regressed, leaving deep atrophic hollows (Fig. 1). There is less pain and tenderness and less local heat and inflammation of the skin.



FIG. 1.

Pemphigus Erythematosus. —Dr. C. H. WHITTLE.

E. H.—, male, aged 78.

First seen 8.iii.46 with a widespread eruption of two months' duration starting between the scapulae and involving all the skin except the face. The lesions were large single blisters and grouped smaller ones on an erythematous base, which broke, leaving oozing red raw areas, almost anywhere. The mouth had blisters and sores. Itching was intense and interfered with sleep. Irregular raised temperature was present for eight weeks, but did not exceed 102° and was mostly below this. He was very ill and in pain, but his morale remained good throughout his illness.

Leucocytes ranged from 3400 to 13,800 per c.mm.

Eosinophil count was never higher than 900 per c.mm.

Previous history.—An outbreak of blisters on the body 16 years previously which cleared up without hospital treatment. "Rheumatic fever" 40 years previously.

Treatment.—In-patient 6 months.

Penicillin intramuscularly, full course; no benefit.

Sulphadiazine by mouth, full course; no benefit.

Suramin intravenously: 0.25 g., 0.5 g., 0.75 g., 1 g., 1 g., every 5 days; total 4.5 g. No toxic symptoms.

Recovery started after 2 weeks' Suramin treatment. New blisters became fewer and finally there were none. General condition returned to normal; some erythema remained.

Course.—Symptom-free for 15 months. Abortive blisters up to 2 in. diameter then appeared between the scapulae but he felt well. He was given more small doses of Suramin and in 2 months was again clear. Fresh itchy blisters and erythematous plaques appeared 15 months later (9.vi.49) on the forearms and back. Arsenic by mouth had no effect, so Suramin (Antrypol I.C.I.) was given, 0.25 g. twice weekly, 5 injections in all. Again the blisters cleared and no new ones appeared until 8 months later (23.ii.50), when blisters up to 1 cm. diameter, some haemorrhagic, again came between the scapulae. These cleared with sulphapyridine 0.5 g. *t.d.s. p.c.* From then on he has had erythematous plaques with occasional blisters on the back and recently one flaccid blister 1 cm. diameter in right axilla. Nikolsky's sign positive.

Histological report (Dr. J. H. Dean) (Section shown.)—A central bulla (11 × 7 mm.) with fissuring in the lower prickle-cell layer and conspicuous acantholysis, although the cavity contains relatively few cells. Many of the prickle-cells bordering the bulla appear refractive and have an eosinophilic cytoplasm: in the deeper layers incipient intercellular oedema and foamy vacuolation of the intercellular interval is evident. There is a moderate degree of chronic inflammatory cellular infiltration (lymphocytes, plasma-cells, eosinophil leucocytes and polymorph leucocytes) of the somewhat oedematous and hyperaemic underlying corium. These features are consistent with a diagnosis of pemphigus.

Conclusions.—When I first saw this man 5 years ago he was gravely ill in hospital, bedridden for 6 months. I had no doubt that he was a case of true pemphigus vulgaris and that he was going to die.

His recovery and subsequent course has shaken my diagnosis, and I do not know in what group to place him. The histology shows typical pemphigus, with blister in deeper layer of prickle cells, and acantholysis (Civate, 1943, 1949; Rook and Whimster, 1950). Perhaps he belongs to the pemphigus erythematosus group of Senear and Usher.

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Pemphigus Erythematosus —Dr. R. E. CHURCH (for Dr. C. H. WHITTLE).

History.—O. D—, aged 45, was well until August 1950 when, while harvesting, he noticed two itchy red marks on his back which he took to be insect bites, but they persisted. In November 1950 his mouth ulcerated and his throat became sore. About three weeks later on combing his head the hair was shed in clumps carrying pieces of skin with it, his scalp crusted and several new red patches appeared on his back.

In April 1951 a crusted erythema appeared in the left axilla and he began to have sores in the nose. During the past month the left axillary lesion has become heaped up and vegetating, and a similar vegetating lesion has appeared in the other axilla. Scattered violaceous lichenoid papules and plaques resembling both lichen planus and lupus erythematosus were present on the backs of hands and wrists until a few weeks ago.

Examination.—A robust man in good general condition. Scattered yellowish impetiginous crusts are present in the scalp, confluent over the vertex and with some surrounding alopecia over the occiput. Over the forehead and cheeks are small

scattered crusts on erythematous bases. There is some crusting in the nostrils. Shallow erosions and remains of bullae with greyish white diphtheroid membranous edges are present over the fauces, palate, buccal mucosa and under the tongue.

Dusky red circinate plaques about 2 cm. diameter with some crusts are present over the sternum and interscapular area. Over these Nikolsky's sign is positive. A few flaccid vesicles on normal skin are present over the back. Heaped-up violaceous moist vegetations are present in both axillae, and over the axillary folds are outlying erosions and remains of bullae.

There are no lesions below the waist.

Investigations.—W.R. and Kahn tests negative.

W.B.C. count 8500 cells mm.³ Normal differential count.

Biopsy taken from the axilla before there was any clinical evidence of vegetation. (Dr. A. M. Barrett): There is an intense inflammatory reaction in the papillary layer of the corium with plasma cells, polymorphonuclear leucocytes and lymphocytes which tends to be perivascular in distribution. There is much acanthosis and conspicuous oedema of the papillary layer of the corium. Stratum granulosum and corneum normal or somewhat thickened.

There is an intra-epidermal bulla containing clumps of degenerating prickly cells, leucocytes and some blood, and showing acantholysis of its wall.

Comment.—The mode of evolution of the Senear-Usher syndrome is of more than academic interest in that it affects the prognosis. Grivaud and Achard (1949) consider it to be a disease entity and divide it into three types. The first begins with lesions resembling seborrhoeic dermatitis on the face and a few bullae on the trunk, which remain stationary for three to four weeks until there is a dramatically sudden generalization of the bullous eruption and rapid death. The second type consists of recurrent acute attacks of a bullous eruption resembling pemphigus foliaceus, but lasting only four to five weeks at a time; a few lesions usually remain on the trunk between attacks. The third type remains mild, chronic and remitting and has an erythematous rash of the face with a few flaccid bullae on the trunk.

Senear and Kingery (1949) have seen cases develop into pemphigus vulgaris of which they subsequently died, and many American authorities regard the syndrome as a benign form of pemphigus vulgaris.

Gray (1938) regarded the syndrome as a variant of pemphigus foliaceus and in this view is supported by Percival (1949), who found that the bullae in both cases are sub-epithelial and thus differ from those of pemphigus vulgaris.

In this patient the onset with impetiginous crusts in the scalp and on the face, bullous lesions in the mouth and crusted greasy circinate macules over the sternal and interscapular regions closely resembled Senear and Usher's original description (1926). The violaceous lichenoid papules and plaques on the backs of the hands and wrists were also described in a case shown by Muende (1939). They have faded since the eruption became more obviously bullous.

During the past three months, despite treatment with penicillin, aureomycin and Antrypol the disease has slowly but steadily progressed: the lesions first in the left axilla and now in the right have assumed a vegetating character, which has only once before been described in the Senear-Usher syndrome (Zeisler, 1936). Seen to-day the case presents the picture of pemphigus vegetans and it seems likely that the prognosis is correspondingly grave.

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Dr. G. B. DOWLING : Is it necessary to separate all these cases of pemphigus ? In pemphigus, especially in the elderly, the lesions may be present in limited areas over a great number of years.

Dr. L. FORMAN : Pemphigus vegetans, although grave, is not necessarily fatal. I have followed three cases over a period of years. Two were young women in whom the disease began acutely with high temperature and many blisters in the mouth and flexures, the base of the blisters vegetating freely. After a severe illness one recovered completely in eighteen months and remained well for a year under observation. The other, after two years of an extensive vegetating dermatosis and blisters in the mouth, recovered save for small areas on the eyelid and scalp. The third, a middle-aged man with extensive vegetations in the flexures, also cleared completely after an illness lasting nearly three years.

Dr. B. C. TATE : I should not have thought the term Senear-Usher syndrome was applicable to either patient. The first cases described presented a definite clinical picture, starting with an eruption like lupus erythematosus, and on the chest and scalp an ill-defined rash like seborrhoeic dermatitis. I think it is useful to keep these subdivisions until we know more about the disease.

I agree that the second patient has pemphigus vegetans, which does not necessarily have a grave prognosis. Three of my patients did extremely well on arsenic and cleared completely. They may have relapsed, but they did remain safe for a considerable period.

Dr. C. H. WHITTLE : The second patient has had only two injections of Antrypol, and it is too early to say that it has not been effective. We are all searching for a criterion in order to make a diagnosis. I still do not know how to distinguish the case that is going to die from the one that is not. I am not yet convinced that acantholysis gives the answer.

P.S. 14.vii.51.—Antrypol has had no effect. Application of 3% aureomycin cream to the lesions has been followed after several weeks by resolution.

Ichthyosis Congenita Bullosa.—Dr. ALAN LYELL (for Dr. C. H. WHITTLE).

B. M.—, aged 6.

History.—At birth there were "raw" areas over the shoulders and knees and shortly afterwards thickening, discoloration and scaling of the skin became evident. Neither at birth nor subsequently has his face been severely affected.

Present condition.—He has typical ichthyosis congenita, with dirty brown-black thickening and scaling of the skin. The shoulders, elbows, knees and dorsa of the feet are most affected, but no part of the skin is normal. Redness of the skin is evident under the scales which are easily removed and quickly reform. The flexures of the elbows, knees and axillae are affected. His scalp is crusted, but the growth of hair is normal. Teeth and nails are well formed. His palms and soles are slightly scaly. He is well developed physically, though slightly small, and is a bright and intelligent child, who is conscious of his disfigurement and of the mild odour from his skin. His hair and nails grow faster than those of his sister. He does not sweat perceptibly.

Family history.—His sister, his only sibling, is normal. There is no skin disease in the family, and his parents are not related.

Bullae.—Six months ago bullae appeared on his skin for the first time, and his general health deteriorated. He is said to have suffered from gastritis and influenza at this time.

When seen a month ago he had about a dozen flaccid bullae on his trunk and the proximal parts of his limbs. All contained pus from the earliest stage. They were thin-walled, ruptured easily, and were succeeded by oozing, raw surfaces which healed in a day or two without any scar.

Investigations.—Pus from an unruptured bulla yielded a heavy growth of Group A haemolytic streptococci, and a few colonies of coagulase-positive *Staphylococcus aureus*. Pus cells and cocci were plentiful in a Gram-stained section of the skin, and were seen only in the blister, which was sub-corneal. The section also showed that none of the epidermis was normal; the unblistered part displayed hyperkeratosis and acanthosis. Groups of prickly-cells were vacuolated, and the stratum granulosum was thickened and unusually blotchy. The lower epidermal layers were in a state of great mitotic activity. The elastic tissue appeared normal.

Course.—Sulphamezathine given by mouth for a week, to a total of 20 g., as a precaution following the biopsy cleared the bullae completely, but a few have re-

appeared since. He has also had ultraviolet light baths, and his general condition has been restored.

Comment.—This boy has had an abnormal skin from birth. The widespread ichthyotic change involving the flexures, the dirty brown scaling and the mild reddening of the skin all proclaim that he is suffering, not from ichthyosis vulgaris, but from ichthyosis congenita, which I hold as synonymous with the ichthyosiform erythrodermia of Brocq.

Upon this abnormal skin bullae have suddenly appeared for the first time. These bullae have been flaccid, purulent from the first, thin-walled and liable to rupture, giving place to raw areas which have healed without scarring.

There seemed to be two aetiological possibilities, the one an epidermolysis bullosa and the other an infection. Epidermolysis seemed unlikely in view of the distribution of the bullae away from pressure points, the mother's allegation that trauma played no part in their production, and the pus which they contained from their inception. The infective nature of the bullae was confirmed by the growth of Group A haemolytic streptococci from an unruptured bulla, by the resolution of the blisters during a course of sulphamezathine and by the histological appearances.

Section of a recent bulla showed a collection of pus under the horny layer, and Gram staining displayed many cocci. The section also showed that none of the epidermis was normal. In the unblistered skin, apart from the anticipated hyperkeratosis and acanthosis, there was a vacuolar change in groups of prickle cells reminiscent of pictures of the histology of epidermodysplasia verruciformis. In addition the whole of the skin, blistered and unblistered alike, displayed intense mitotic activity.

This case confirms the observations of Goldsmith (1928) that bullae in ichthyosis congenita can be infective in origin, and are presumably the result of invasion by pathogenic cocci. Neither in his case nor in ours was there any evidence of epidermolysis bullosa.

By contrast, a case described by Reyes (1945) produced bullae as a result of trauma, and a histological abnormality of the elastic tissue was observed. It is true that Reyes called his case epidermodysplasia hystericoidis bullosa, rejecting a diagnosis of ichthyosiform erythrodermia; but he did so, I think, wrongly, in view of the recorded clinical features, and particularly the fact that the child at birth seems to have resembled a "collodion foetus." Of particular interest to me is the histology of the skin of his patient, which, with the vacuolation of prickle-cells, recalls the changes seen in our case.

Apparently bullae in ichthyosis congenita can be due to infection or epidermolysis; our case represents the infective type.

REFERENCES.

- GOLDSMITH, W. N. (1928) *Brit. J. Derm.*, **40**, 59.
REYES, J. G. (1945) *Arch. Derm. Syph., Chicago*, **52**, 328.

Dr. F. PARKES WEBER: Was Dr. MacLeod the first to introduce the term "ichthyosis bullosa?"
Dr. A. LYELL: I think this term was first used by MacLeod about 1928.

Case for Diagnosis—? Lupus Erythematosus.—Dr. I. MARTIN-SCOTT.

I. C—, aged 41.

History.—This patient, first seen in January 1950, complained of painful erosion of the ears for six months. The lobes showed some loss of flesh, slight ulceration, considerable cyanosis, moderate telangiectasia and follicular plugging. Routine investigations were negative, and a section was consistent with lupus erythematosus. He was treated for nine months with vitamin E and local rubefacients without improvement.

Towards the end of last year disseminated annular lesions developed on the forehead, shoulder, left cheek and hand, and the lateral aspects of both feet. These plaques were cyanosed, and bounded by a firm elevated annular ridge. On the feet

and hand the lesions developed a central slough—rather like an infarct—but the ulcers healed rapidly.

As these new lesions resembled a circinate sarcoid, he was treated with Calciferol but showed no improvement after three months: Two subsequent biopsies did not show the features of sarcoid. Recently there has been some improvement following local application of a bismuth ointment.

There have been no systemic manifestations.

Past health. Apart from three attacks of malignant tertian malaria abroad in 1942 he has enjoyed good general health.

Investigations.—The following have been done:

Skiagrams of chest in January and December 1950 showed slight enlargement of the hilar shadows. Skiagram of the hands showed no cystic changes.

E.S.R. on two occasions normal.

Albumin-globulin ratio, April 1951: 2.9/1.0. Total protein 6.5 mg.%; albumin 4.4 mg.%; globulin 2.1 mg.%; serum calcium 10.8 mg.%

W.R. and Kahn: December 1950 and April 1951, negative.

Mantoux reaction, December 1950: 1/1000 doubtful positive; April 1951: 1/1000 doubtful, but 1/100 gave strong positive.

Three biopsies from different sites have been done during the period of observation. All sections showed slight widening of the follicular ostia with some associated localized hyperkeratosis; and a moderate lymphocytic infiltrate chiefly around the skin appendages.

Treatment. January to October 1950, 300 mg. vitamin E daily, and Priscoil ointment locally. November 1950 to February 1951, 150,000 units D₂ daily.

Whilst in hospital in April 1951 he had a ten-day course of Streptomycin 1 g. intramuscularly daily and a seven-day course of systemic Penicillin 300,000 units daily. He has also been taking preparations containing nicotinic acid from time to time, and rubefacient ointments have been applied. Recently he has considerably improved after the application of bismuth oxychlor. 6%: zinc oxide, adeps lan. hyd., ol. arachis, ã 12%: paraff. moll. flav. ad 100% (Sig.: apply twice daily), which was prescribed by Dr. W. N. Goldsmith.

Comment.—I have shown him to-day in the hope that members may confirm my tentative diagnosis; and because, if the diagnosis of lupus erythematosus is agreed with, there are some rather interesting features.

Eighteen months ago the lesions were confined to the ears, and my diagnosis of lupus erythematosus was confirmed histologically.

Routine investigations were negative, and he was unsuccessfully treated with 300 mg. of vitamin E daily and local rubefacient ointments. Towards the end of 1950 he clinically resembled a circinate sarcoid or lupus pernio (Besnier), but this was excluded by laboratory findings and two subsequent biopsies; and examination at the Tropical Hospital showed no evidence of leprosy.

The most likely diagnosis would seem to be the chilblain lupus of Hutchinson, as the clinical features conform very closely to his original description in 1879. Jonathan Hutchinson first drew attention to the symmetry of the lesions, which were on the ears, cheeks, nose, hands and feet, and describing the hands of such patients he states: "They are deeply congested, and the patches of congestion are well margined and with slightly raised edges. They are rough on the surface from epidermic peeling, and here and there accumulations of horny epidermis have formed, but nowhere is there actual ulceration or pus-scab. There are numerous scars left where the inflammation has ceased."

Postscript. When last seen in June the lesions were flat and less cyanotic. A course of bismuth was recommended.

REFERENCE.

HUTCHINSON, JONATHAN (1879) *Lectures on Clinical Surgery*, 1, 287.

Dr. L. FORMAN : The section showed localized changes in the cutis surrounded by zones of infiltrate suggesting granuloma annulare or necrobiosis. Were any vascular changes demonstrated ?

The PRESIDENT : When I saw the patient the patches were raised but rather soft, and reminded me of the consistency of erythema multiforme rather than that of granuloma annulare.

Dr. J. SOMMERVILLE : To me the condition suggested granuloma annulare or erythema perstans. As the condition is disappearing rather quickly, one must fall back on the diagnosis of a process of erythema associated with the other toxic condition of lupus erythematosus.

Dr. I. MARTIN-SCOTT : The histological sections showed no evidence of localized degeneration as one would expect in necrobiosis lipoidica or polyarteritis nodosa ; and the patient has never shown any evidence of visceral disease. I hesitate to accept the suggestion that my patient suffers from lupus erythematosus of the ears and a toxic erythema elsewhere, as it does not quite fit chronologically or histologically.

Kaposi's Disease.—Dr. S. P. HALL-SMITH (for Dr. W. J. O'DONOVAN).

Mrs. A. H—, aged 80.

History from patient's daughter.—Condition believed to have started early in April 1951. Apparently sudden onset of what looked like " blood blister " on sole of left foot. Some irritation, but no pain. No bleeding or discharge from the lesion.

About then the relatives noticed three small purplish nodules which resembled bruises on the left shin. About a week later similar lesions appeared on the right shin. She was then referred to hospital.

For the past nine months some swelling of the left ankle and over past three months some loss of weight have occurred.

Occasional incontinence of urine and faeces.

Past history.—Health good apart from winter bronchitis.

Family history.—Ten children. Nil relevant.

On examination.—Thin and cachectic old lady. Mentally disorientated. No lymphadenopathy. General medical examination normal.

Skin, sole of left foot.—Raised, irregular, crusted and haemorrhagic mass. Adherent lesions over both shins.

Investigations.—8.v.1951 : Hb 74%, W.B.C. 18,500. Polys. 82%, lymphocytes 15%, monocytes 3% ; red cells and platelets normal.

11.v.1951 : W.B.C. 11,400. Polys. 72%, eosins. 2%, lymphocytes 18%, monos. 8%.

E.S.R. 50 mm. per one hour.

Histology.—The microscopical appearances are compatible with those of idiopathic haemorrhagic pigment-cell sarcoma of Kaposi.

Skiagram of chest.—There is mottled loss of translucency in both lung fields predominating in the upper zones and confluent on the left where there are several irregular cavities. The lesions are associated with fibrosis and the appearances suggest pulmonary tuberculosis.

Behcet's Syndrome.—Dr. PETER BORRIE.

Mr. H. T—, an Armenian, aged 21.

History.—At the age of 14 he had an attack of malaria, during which the buccal mucosa began to ulcerate and has continued intermittently ever since. Six months later a typical attack of erythema nodosum was followed by scrotal ulceration, which has also persisted intermittently. At 17 he had a deep purulent ulcer on the back of his left calf, which took 6 weeks to heal. Recurrent uveitis of the left eye began at 18, led to blindness, and the eye was removed 2 years later in 1950. Three months after this, however, the right eye became affected.

During the last few years he has also had recurrent attacks of an eruption of erythema multiforme type on the limbs and extremities, inflammatory pustules and acneiform lesions, and arthralgia and tender periarticular swellings of the feet, ankles and elbows.

Present condition.—The right eye shows multiple signs of uveitis.

Several oval or circular, punched-out ulcers, 2–5 mm. in diameter, with purulent bases, are seen on the sides of the tongue and the buccal mucosa. There is one similar ulcer on the scrotum.

There are occasional inflammatory pustules and acneiform lesions on the trunk and limbs, and on the back of the left calf there is a depressed, pigmented scar 2 cm. in diameter.

No other abnormalities on general examination. Nutrition good.

Investigations.—Skiagram of chest : No abnormality.

Full blood count : No abnormality.

Swab from skin pustule : Scanty growth of coagulase-negative staphylococci.

Skin puncture with a sterile needle caused pustule formation in 36 hours.

Treatment.

1. Subconjunctival Cortisone, 7.5 mg. weekly for 3 weeks : no objective improvement ; some improvement in vision.

2. Six weeks later intramuscular Cortisone, 50 mg. *t.d.s.* for 4 days, 25 mg. *t.d.s.* for 3 days and 25 mg. *b.d.* for 2 days : disappearance of all cutaneous mucosal and joint symptoms and signs. No abnormal reaction following sterile needle-pricks. Some clearing of vitreous opacities.

3. Two weeks later ACTH 35 mg. *t.d.s.* for 1 week : complete disappearance of all except the eye signs, which were improved, but one fresh buccal ulcer appeared during treatment.

Comment.—This is a good example of a fully developed Behcet's disease showing every sign and symptom that has been described except venous thromboses.

The malady, which appears to be an abnormally severe, acute inflammatory reaction to subclinical trauma, can be completely controlled with cortisone, and probably also with ACTH in adequate doses, in all respects except for the uveitis. These drugs do not, however, solve the therapeutic problem.

Dr. J. SOMMERVILLE : Some troublesome cases of genital and buccal ulcers similar to this have responded to fever therapy where most other things failed. I have seen three in the past 18 months where the ulcers have steadily healed since the patients have been given non-specific fever therapy. If it is said that we do not know what we are doing in non-specific fever therapy, the same applies to administering the new very expensive drugs. In fever therapy a sharper reaction is obtained, which may be of more benefit than something less well understood.

Dr. R. M. B. MACKENNA : I have treated two cases with aureomycin. One, a young man, improved while under treatment, but out of hospital he had a very severe relapse. The other, a young woman, did not respond and became very much worse.

Dr. E. WADDINGTON : I have treated one case with aureomycin without the slightest effect. This patient was later given a course of intravenous T.A.B. vaccine which produced a complete remission.

Dr. H. HABER : The one patient to whom I gave aureomycin developed a new crop of ulcers around the anus and was worse than before.

The PRESIDENT : One patient with incomplete Behcet's disease involving only the mouth and the vulva did not respond to aureomycin, but did respond to chloramphenicol in large doses and this seemed constant in its effect.

Hydradenitis Suppurativa. Dr. W. N. GOLDSMITH.

Mr. W. R. H., aged 29, referred to me by Sir N. Hamilton Fairley, was previously shown at this Section on 17 November 1949, when the prevalent opinion was that surgical treatment held out the best prospects, and he is presented again now to show the successful outcome.

Treatment and progress.—Between December 1949 and May 1950 Mr. Naunton Morgan carried out three operations on the buttocks and perineum under general anaesthesia, laying open the sinuses and allowing the wounds to granulate from the bottom. Dr. W. H. Jopling performed three lesser operations of the same nature under pentothal anaesthesia between May and October 1950. Post-operative treatment consisted of daily baths and eusol dressings. The results were very gratifying,

only three small discharging sinuses remaining by the end of 1950. In July 1950 Mr. Morgan operated on the left axilla, and all the sinuses in this area have healed completely. Sections of material taken at the time of the first operation were sent to Dr. Cuthbert Dukes, who reported as follows (section shown):

"The sections are very peculiar. They show a fistulous track, completely lined by stratified squamous epithelium, and surrounded by fibrous tissue. There are no hairs, hair follicles, sweat glands or sebaceous glands in the fistulous track, and the diagnosis would seem to lie between a pilonidal sinus or an epithelialized simple fistula."

Dr. D. S. Ridley, pathologist at the Hospital for Tropical Diseases, reported as follows on tissue and a lymph gland taken from the left axilla:

"In the deeper layers of the skin there is a granulomatous reaction rather suggestive of tuberculosis, superimposed on which is a great deal of purulent inflammation. The whole process is fairly effectively walled off from the more superficial dermis by a layer of fibrous tissue; the axillary gland shows a non-specific inflammatory hyperplasia. No acid-fast bacilli found."

I saw this man again in November 1950, and to clear up the few small remaining sinuses referred him to Dr. H. Burt, who gave him infra-red and Kromayer treatment.

The following cases also were shown:

Chronic Oedema of Hands and Face.—Dr. E. J. MOYNAHAN.

Exfoliative Dermatitis Treated with A.C.T.H. and Cortisone. Dr. E. J. MOYNAHAN.

NOTICE.

TENTH INTERNATIONAL CONGRESS OF DERMATOLOGY.

THE Museum Sub-Committee would much appreciate the loan, for exhibition purposes, of old or rare dermatological books or manuscripts. The risk of damage by mishandling will be obviated by displaying them in glass cases, each with a descriptive note. To avoid duplication members able to contribute are requested in the first instance to send a list of titles to the Secretary-General to the Congress at St. John's Hospital, Lisle Street, Leicester Square, London, W.C.2.

BOOK REVIEW.

ECZEMA.*

THIS is a simple common-sense account. Eczema is a syndrome and not a disease, a reaction to numerous aetiological factors; we therefore read about microbic and mycotic eczemas in addition to what is more strictly called eczema in this country. Clinical lesions are subdivided into more numerous types than in English books; there is also a chapter dealing with lesions topographically. In discussing aetiology little reference is made to psychological factors and this is reflected in treatment, where phenobarbitone is not mentioned. A chapter is devoted to infantile eczema, which is attributed largely to dietary faults. The chapter on treatment is simple and helpful but contains no mention of x-rays, and the authors attribute more value to vitamins E and F than the reviewer would. The articles which should be avoided in the diet bring back memories of continental holidays. This monograph is well worth reading by the English dermatologist, who will find the different approach stimulating.

F. F. H.

* *Les Eczemas et leurs Traitements.* By P. CHEVALLIER and M. COLIN. Les Monographies Medicales et Scientifiques No. 11. Paris: Editions "Heures de France," 1951.

CURRENT LITERATURE.

CAPILLARY FINDINGS TREATED STATISTICALLY. A. LUGER. (1951) *Derm. Wschr.*, **124**, 767.

The author has devised a statistical method for analysing his findings with the capillary microscope in circulatory derangements of the lower extremities. He notes the thickness of the vessels, their form, calibre and current, expressing the degree of abnormality as a figure thus: the normal, 0; noticeable thinning or thickening, 1; considerable thickness or thinning, 2; very thin, or maximal thickness, 3; and similarly with abnormalities in other respects. In all 61 patients were investigated. In varicosity without ulcer the capillaries showed the least departure from the normal. They were more abnormal in the presence of an ulcer of venous, or venous plus arterial genesis, and most marked in circulatory derangements of arterial origin. With leg ulcers no relationship could be found between the age of the patient and the degree of capillary change.

M. S. S.

PSYCHOTHERAPY OF PSYCHOGENIC PRURITUS. H. J. SONNECK. (1951) *Derm. Wschr.*, **124**, 693.

The author reports success with psychotherapy in three cases, described in detail, of psychogenic pruritus intractable to all previous treatment. Cases so diagnosed should, in his opinion, be referred to the psychiatrist, as the treatment is time-consuming and the environment of the skin clinic is not suitable. He favours a combination of psycho-anamnesis with symptom analysis according to Steckel, and fractionated (easily learned) active hypnosis (Kretschmer).

M. S. S.

A REVIEW AND CRITIQUE OF THE CAUSATIVE ROLE OF FOOD ALLERGY IN ECZEMATOUS DERMATITIS. DANIEL E. PERRY. (1951) *Urol. and cutan. Rev.*, **55**, 309.

This is an attempt to assess the perennial problem of the detection of food allergens responsible for eczematous eruptions. The manifestation occurs in localized patches or plaques on various sites, but more commonly on the dorsa of the hands; less on the feet, eyelids, legs, arms, face, scrotum, groins, neck, axillae, buttocks and peri-anal region." Certain broad conclusions of practical value are reached:

1. Skin tests are useless and even misleading.
2. Food allergy should be sought when other causes such as contact allergy and infections have been eliminated.
3. Food allergy is established as a cause of eczema, but is uncommon.
4. Elimination diets and the addition of a single food at a time offer the best means of discovering the agent: the difficulties are obvious—either the patient must occupy a bed for weeks in hospital, or he must be exceptionally intelligent and co-operative as an out-patient if the tests are to be successfully carried out.
5. Test elimination diets and menus are suggested. (Most appetizing, but almost unattainable in this country at present.)
6. Food diaries may be used to supplement or confirm the results of adding article by article to elimination diets, but are difficult to interpret without such guidance.
7. Lichen simplex may be due in some cases to food allergy.
8. The products of breakdown or digestion of foods may be the allergens rather than the foods themselves.

C. H. W.

EXPERIENCES WITH PODOPHYLLIN OINTMENT. NORMAN O. FARRELL. (1951) *Urol. and cutan. Rev.*, **55**, 318.

Two and a half per cent. podophyllin ointment was applied once weekly for 8–24 hours and then washed off. The lesions treated were nummular eczema and "hypertrophic neurodermatitis." Eighteen out of 20 patients got well.

C. H. W.

BLASTOMYCOSIS EN PLAQUE. JOSEPH C. SODARO and CLEVELAND J. WHITE. (1951) *Urol. and cutan. Rev.*, **55**, 209.

A brownish-red plaque of 3 months' duration and two inches diameter on the forehead of a woman, aged 52, was found on biopsy examination to contain budding blastomyces in the epidermis. It responded to oral potassium iodide and vanished in six weeks.

C. H. W.

AUREOMYCIN IN THE TREATMENT OF ACTINOMICOSIS. L. L. McVAY, F. GUTHRIE and D. H. SPRUNT. (1951) *New Engl. J. Med.*, **245**, 91.

Three cases of cervicofacial and one of abdominal actinomycosis treated successfully with aureomycin are reported.

In vivo sensitivity tests established an inhibitory action by aureomycin on actinomycosis bovis. The rapid clinical response, ease of administration and absence of significant toxic effects suggest that aureomycin is the agent of choice in treatment.

A. D. P.

ADVANCES IN THE TREATMENT OF SEBORRHOEIC DERMATITIS AND ACNE VULGARIS.

GEORGE C. ANDREWS, CHARLES F. POST and ANTHONY N. DOMONKOS. (1951) *Austral. J. Derm.*, **1**, 11.

Success is reported in the treatment of seborrhoeic dermatitis with weekly (sometimes more frequent) injections of 10–30 micrograms of vitamin B₁₂ in addition to the usual local applications. Improvement is said to manifest itself after two or three injections and the results to be far superior to those obtainable by local treatment alone.

It is unfortunate that these claims are not supported by reports of an adequately controlled therapeutic trial.

The section on treatment of acne vulgaris is interesting in so far as it reports a swing away from radiotherapy. The authors have not used x-rays for two years, and claim that their results are superior to those obtained in the previous ten or fifteen years when x-ray was regarded as the mainstay of treatment.

Their methods include a low fat diet, vitamin A, comedone extraction, lotio alba or other sulphur preparations, Vlemingck's solution, routine treatment of the scalp, eradication of septic foci, stilboestrol, crude liver extract, desiccated thyroid, and rationalization of mental conflicts. In pustular cases, antibiotics and sulphonamides of all types are used according to the susceptibility of the organisms isolated from pustules. It is interesting to note that in certain patients sulphadiazine was given in small doses for five or more weeks, and aureomycin and terramycin in doses of 1 g. daily for one or two months.

Residual scarring is treated with ultraviolet or cold quartz light, or applications of carbon dioxide slush.

R. B.

SYMPOSIUM ON WARTS: WARTS AND THEIR TREATMENT. JOHN C. BELISARIO. **WARTS AND THEIR TREATMENT.** R. F. A. BECKE. **TREATMENT OF WARTS.** W. W. LEMPRIERE. **DISCUSSION ON WARTS.** (1951) *Austral. J. Derm.*, **1**, 20, 31, 34 and 37.

It is gratifying to see a presidential address, two comprehensive articles, and a discussion, all devoted to these ubiquitous, time-consuming and recalcitrant growths.

Between them they give a comprehensive picture of diagnosis and treatment, the latter ranging from psychiatry to pyrotechnics.

R. B.

PSYCHOSOMATIC FACTORS IN DERMATOLOGY. JOHN H. KELLY. (1951) *Austral. J. Derm.*, **1**, 39.

PSYCHOLOGICAL ASPECTS IN DERMATOLOGY. A. J. M. SINCLAIR. (1951) *Austral. J. Derm.*, **1**, 53.

These papers review the present position at some length, and emphasize that the patient's reaction to his disease should be taken into account, even when his disorder is predominantly organic in origin. An attempt is made to define the circumstances in which expert psychiatric aid should be sought.

Dr. Kelly provides some thoughtful criticism of the allergic approach to such problems as infantile eczema.

Dr. Sinclair gives examples of the skin diseases which accompany certain personality disorders, and which may be related to them aetiologically.

R. B.

A SUGGESTED METHOD OF SPREAD OF MOLLUSCUM CONTAGIOSUM IN QUEENSLAND.

B. B. BARRACK. (1951) *Austral. J. Derm.*, **1**, 60.

Molluscum contagiosum arose in certain individuals who appeared to have had no contact with others suffering from the disease and had not attended swimming-pools or Turkish baths. At least 50% of them had contact with birds or bird mites, and it was considered that these mites could be the vectors of the virus. No attempt was made to transmit the disease by this method under experimental conditions.

R. B.

EXTERNAL IRRITANTS IN FACIAL DERMATITIS. W. C. T. UPTON. (1951) *Austral. J. Derm.*, **1**, 64.

The author lists the same causes as are common in this country, and in addition, a number of plants, including the shrub wormwood (*artemissa*), liquorice weed, stinkwort, sun spurge, Queensland maple, blackwood, dogweed, pyrethrum (used as a fly killer), and silky oak (*Cardwellia sublimis*). R. B.

A CASE OF SARCOMA IDIOPATHICUM HAEMORRHAGICUM KAPOSI. F. GOLDSCHLAG. (1951) *Austral. J. Derm.*, **1**, 69.

A man, aged 65, with fever, itching and enlargement of the liver, spleen and lymph glands, developed a skin eruption three years later. Biopsy of this showed the picture of Kaposi's disease. There is no report of an autopsy. R. B.

TROPICAL LICHENOID DERMATOSIS. R. B. PERKINS. (1951) *Austral. J. Derm.*, **1**, 75.

The author reports twelve patients seen in 1944, diagnosed as having tropical lichenoid dermatosis. Alternate cases were treated with and without atabrin, because at that time there was doubt as to the aetiological role of this drug. The clinical course of the two groups differed sufficiently to confirm the opinion that atabrin caused, or at least aggravated, the eruption. R. B.

PROGNOSIS OF DERMATITIS HERPETIFORMIS, TREATED AND UNTREATED. WILLIAM H. EYSTER, JR., and ROBERT R. KIERLAND. (1951) *Arch. Derm. Syph., Chicago*, **64**, 1.

From 1920 to 1939, 381 patients diagnosed as suffering from dermatitis herpetiformis attended the Mayo Clinic out of approximately 200,000 dermatological patients, i.e., 1 in 500. The ratio of males to females was 2.7 to 1; the age at onset varied from 6 months to 78 years, but in 61% was between 20 and 45 and in 77% between 20 and 55. Definite information on the subsequent course of the disease was obtained from 249 patients or relatives. In 35% the disease was in remission, 29% still had the disease, but their symptoms were much less severe and less frequent, 24% were *in statu quo*, 12% were dead with the disease still present at the time of death. Dermatitis herpetiformis lasted from 2 to 40 years, and the severity at the time of examination had no bearing on the time the disease was to last. The disease in the majority of cases retained its original severity for a number of years (of the order of 10), and then gradually tapered off until it became quiescent, unless death occurred from some other cause. One infers from the article that the mortality from the disease in this series was *nil*. J. K.

ORAL ADMINISTRATION OF PROCAINE WITH ASCORBIC ACID, WITH SPECIAL REFERENCE TO THE THERAPY OF PRURITUS. HUGH LUDDECKE. (1951) *Arch. Derm. Syph., Chicago*, **64**, 9.

The author treated 10 patients with 250 mg. procaine hydrochloride and 150 mg. ascorbic acid or double this amount by the mouth every 3 hours to 4 times daily. The conditions treated included atopic dermatitis, unspecified dermatitis, penicillin reactions and urticaria. The results were dramatic in 9 cases, while in the other (atopic dermatitis) the symptoms were made worse. It is a pity the series is so small and the amount administered so variable. J. K.

MELANIN PIGMENTATION AND HEPATIC DISEASE. F. A. WHITLOCK. (1951) *Arch. Derm. Syph., Chicago*, **64**, 23.

The author describes 4 cases of hepatic cirrhosis with associated darkening of the skin due to increased presence of melanin. He suggests that in these cases and in acanthosis nigricans severe liver damage or relative insufficiency produces a failure of the oestrogen-detoxifying mechanism. The free circulating oestrogen possibly acts on the skin sulphhydryls and so releases the melanin-forming oxidases. J. K.

FURTHER STUDIES IN AUTOECZEMATIZATION. BRUCE M. ESPLIN and FRANK E. CORMIA. (1951) *Arch. Derm. Syph., Chicago*, **64**, 31.

The preliminary report was abstracted in this journal. The present study confirms the previous finding that the antigen is a water-soluble component of epidermal cells. The antigen may be transported from the primary site by eosinophil leucocytes. J. K.

TREATMENT OF SEBORRHOEIC DERMATITIS WITH A SHAMPOO CONTAINING SELENIUM DISULPHIDE. WILLIAM N. SLINGER and DONALD M. HUBBARD. (1951) *Arch. Derm. Syph., Chicago*, **64**, 41.

The shampoo consisted of a watery 2.5% solution of selenium disulphide with a "surface-active agent" and inert and stabilizing ingredients. It was used twice weekly at first and later once a week in 90 cases of seborrhoeic dermatitis with "complete control" in the vast majority of cases. No instance of sensitization or of absorption of selenium was encountered. J. K.

PAPULAR WASP-STING ERUPTION. C. E. SONCK. (1951) *Acta allergol.*, **4**, 1.

The author describes the case of a man aged 39, stung by a wasp, who 4 days later developed a disseminated papular rash resembling syphilis. The eruption, which disappeared within two weeks, was considered to be a toxic or allergic reaction to the wasp sting. H. T. H. W.

QUINIDINE ALLERGY. R. and A. CHRISTENSEN. (1951) *Acta allergol.*, **4**, 37.

A woman, aged 42, who was treated with quinidine sulphate for rheumatic heart disease developed, after 35 days' treatment, a generalized pruritic scarlatiniform eruption. This was followed 19 days later by a thrombocytopenic purpura. She completely recovered a week after quinidine was discontinued. H. T. H. W.

COLLECTED CASES OF INOCULATION LUPUS VULGARIS. S. HELLERSTROM. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 194.

Six cases of primary inoculation lupus vulgaris of the face following accidents in a swimming-pool—five from the same pool. G. A. H.

CASES OF TUBERCULOSIS CUTIS TREATED WITH PARA-AMINOSALICYLIC ACID (P.A.S.).

B. LINNROS. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 217.

Improvement followed the use of para-aminosalicylic acid in cases of scrofuloderma, tuberculous facial ulcers, erythema induratum, and lupus vulgaris of the nasal mucous membrane. G. A. H.

ON THE EXCRETION OF GONADOTROPIC, OESTROGENIC AND ANDROGENIC SUBSTANCES IN THE URINE OF PATIENTS SUFFERING FROM ERYTHEMA INDURATUM (BAZIN).

J. KNAP and N. DANBOLT. (1951). *Acta dermat.-venereol., Stockh.*, **31**, 219.

Titration of the urine were made for gonadotropic oestrogenic hormones in patients with erythema induratum (Bazin). A clear majority showed a reduced secretion. Oestrogen has an antitoxic effect and also a hyperemizing vasodilatory effect in the extremities.

It is suggested that where tuberculo-toxins circulate when the oestrogen production be insufficient the toxic effect may not be neutralized, and any circulatory disturbance will be aggravated by the absence of the vasodilatory effect of oestrogen. G. A. H.

ON THE USE OF VITAMIN E IN DERMATOLOGIC PRACTICE. G. HAGERMAN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 225.

It is claimed that acrodermatitis atrophicans progressiva (Herxheimer) improves rapidly with vitamin E therapy. G. A. H.

ERYTHEMA CHRONICUM MIGRANS AFZELIUS WITH MENINGITIS. S. HELLERSTROM (1951) *Acta dermat.-venereol., Stockh.*, **31**, 227.

Erythema chronicum migrans (Afzelius), with or without meningitis, may be due to an infective agent (? spirochaete) with allergizing (and ? immunizing) behaviour, the organism being transmitted by ticks and possibly other insects. G. A. H.

SUCCESSFUL TREATMENT OF ERYTHEMA MIGRANS AFZELIUS. E. HOLSTROM. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 235.

Rapid therapeutic action resulted from the use of bismuth, neoarsphenamine, mapharside and penicillin either separately or in combination in 14 cases of erythema migrans (Afzelius). Penicillin was superior in action to the other drugs, and had a rapidly curative effect in a case with frank meningitis. G. A. H.

ON THE SKIN TEST WITH SARCOID TISSUE SUSPENSION (KVEIM'S REACTION). N. DANBOLT. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 184.

Kveim's reaction is considered to be of allergic nature. Results of investigations on a heterogeneous collection of patients make it improbable that the reaction is a Köbner phenomenon.
G. A. H.

EXPERIMENTAL INVESTIGATION OF THALLIUM POISONING. N. THYRESSON. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 133.

A study of the effect of thallium on the growth and differentiation of hairs and epidermis in young rats and in tissue cultures of embryonic rat skin. Thallium has no effect on mitosis of cells, where a process of differentiation leading to keratin formation occurs in the cytoplasm.
G. A. H.

POSSIBLE TUBERCULOUS SKIN INFECTION FROM A SWIMMING POOL. D. E. H. CLEVELAND. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 147.

Localized granulomatous lesions appeared at the site of abrasions sustained in a swimming-bath in four patients, which clinically and histologically suggested tuberculosis cutis. No tubercle bacilli were found and the tuberculin tests where done were negative.
G. A. H.

THE WASSERMANN REACTION OF THE BLOOD IN THE UMBILICAL CORD. O. NORGÅRD. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 153.

The authors confirm the statement of previous authors that the cord blood may give positive sero-reactions caused by antibodies in the mother's blood. It is not possible to decide from the reactions in cord blood whether they are caused by antibodies from the mother or by infection in the child, but a strongly positive Meinicke test suggests that the child has congenital syphilis.
G. A. H.

DIHYDROSTREPTOMYCIN IN GONORRHOEA. T. PUTKONEN and S. ROUCHUNDKOSKI. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 391.

When 143 female patients were treated with dihydrostreptomycin with a dose of 0.4 g. daily 96.6% recovered as opposed to 76.7% with a dose of 0.2 g. and 66.7% with a dose of 0.1 g. daily. Subsequent observation for one week will detect recurrences and the treatment will not mask coexisting syphilis.
G. A. H.

A PRIMARY CHANCRE OF THE VAGINA. T. PUTKONEN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 395.

An unusual case of a young woman who developed a primary chancre of the upper third of the vagina.
G. A. H.

INVESTIGATIONS OF METABOLITES IN ACUTE ECZEMA AND ERYTHRODERMA. A. NORMAN and O. LÖRGREN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 398.

In so far as citric acid may be considered a metabolite in the carbohydrate metabolism and iron a catalyser, the investigations point to a disturbance of the carbohydrate metabolism in uncomplicated acute eczematous diseases or erythroderma; and such disturbance in the authors' cases being characterized by a low excretion of urinary 17-ketosteroids may possibly be attributed to suprarenal function.
G. A. H.

CONGENITAL POIKILODERMA ATROPHICANS VASCULARE IN A MOTHER AND HER SON. N. HALLMAN and R. PATIALA. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 401.

Account of an atrophic skin change with telangiectases, pigmentation, capillary haemorrhages and atrophy noted histologically in a mother and her son which had started at suckling age, spreading symmetrically to cheeks, nose, ears, hands, feet, legs and buttocks.
G. A. H.

CASE OF KAPOSI'S SARCOMA TREATED WITH PENICILLIN. G. SJÖGREN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 419.

A case of Kaposi's sarcoma, confirmed histologically, was treated with penicillin. A total of 20.8 million units was given in 3 weeks together with vitamin E 150 mg. daily; its effect was uncertain. Subsequently treatment with radiotherapy caused regression of the lesions.
G. A. H.

TUBERCULIN SENSITIVITY IN LYMPHOGRANULOMATOSIS BENIGNA. G. SEEBERG. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 426.

A study of 15 cases of benign lymphogranulomatosis tested with tuberculin in saline and depot tuberculin (tuberculin in a vehicle of liquid paraffin and adeps lanae).

Seven cases were Mantoux-positive, giving more prolonged and stronger reactions to D.T. than to Mantoux; eight were clinically negative to 1 mg. tuberculin in saline, but six of these gave quite a strong and long lasting reaction to D.T. G. A. H.

INCREASE OF SENSITIVITY TO ORGANIC LUTEIN ON REPEATED TESTING. G. SEEBERG. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 442.

The majority of 28 children with congenital syphilis showed a progressive increase in skin sensitivity when intra-cutaneous tests with organic lutein were twice repeated at 6-day intervals. G. A. H.

TREATMENT OF LICHEN RUBER PLANUS AND PITYRIASIS LICHENOIDES CHRONICA WITH 2-METHYL-1:4-NAPHTHOQUINONE (VITAMIN K-LIKE SUBSTANCE). P. PIIRILA. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 52.

Ten to twenty intramuscular injections of 2-methyl-1,4-naphthoquinone (a vitamin K-like substance) were given to 10 cases of lichen ruber planus. Itching ceased within a week in the 7 cases that were cured, whilst 3 were not improved. Cure was also claimed of 4 cases of pityriasis lichenoides chronica in about a month. G. A. H.

TREATMENT OF PLANTAR WARTS. G. AUKEN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 79.

The best treatment of plantar warts is with radium and a 95% cure rate is claimed. Electro-coagulation with subsequent weekly painting with 50% silver nitrate is the second choice. G. A. H.

DERMATITIS OF THE EYELIDS. O. KAALUND-JORGENSEN. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 83.

Periocular dermatitis is common in middle-aged women. It may be xerotic or seborrhoeic in type but most commonly is allergic. Difficulties arise in determining the causal agents, which are primarily cosmetics and plants, because the hypersensitivity may be entirely local, and also because patients may be allergic to more than one substance in a given case.

Seventy-five cases showed a distribution of agents as follows: Cosmetics (including shampoo) 21, potted plants 13, insecticide powder 1, drugs used externally, e.g., penicillin, atropine, etc., 6, Pinene 7, bakelite 1, printer's ink, 2 seborrhoeic eczema 8, mental factors 5, obscure (including climatic conditions, 2) 6. G. A. H.

ECZEMA DUE TO THE WOOD OF PEROBA DA CAMPOS: ISOLATION OF THE ALLERGEN.

DE JONG, LENSTRA and D. J. H. VERMEER. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 108.

The causal agent in dermatitis due to peroba da campos, an imported wood from Brazil, was found to be a crystalline substance, lapachonon. G. A. H.

LIPOMELANIC LYMPHADENOPATHY. F. R. BETTLEY. (1951) *Acta dermat.-venereol., Stockh.*, **31**, 111.

A case report of lipomelanitic lymphadenopathy in a man, aged 35. The condition started as a typical psoriasis which became widespread as unusually thickened scaling skin with severe excoriations and generalized enlargement of the lymph-glands; liver and spleen were not enlarged. As the skin improved so the enlargement of the lymph-glands receded. Gland biopsy showed general infiltration with mainly large cells with clear cytoplasm and round or oval nuclei. Masses of brown pigment appeared in some areas which did not give the reaction of iron. The appearances were typical of lipomelanitic reticulosis. It is claimed that although this is the first case reported, generalized lymphadenopathy is not uncommonly found in psoriasis where erythroderma has supervened.

The author, after full discussion of other cases, believes that there is no justification for the use of the term "reticulosis" (which assumes a progressive hyperplasia), and that the condition would be better called lipomelanitic lymphadenopathy. G. A. H.

TREATMENT OF SKIN DEFECTS BY BLOOD METHOD. L. J. HOLCK. (1951) *Acta dermat. venerol., Stockh.*, **31**, 121.

The healing time of various skin defects such as ulcerations was shortened by a quarter, by the application of gauze soaked in blood with sulphanilamide or penicillin. Venous blood is preferred to plasma or corpuscles only.

Where plastic skin grafts were required the blood coagulum can be used as a cover to aid healing. G. A. H.

ON THE TREATMENT OF PERIARTERITIS NODOSA. J. JORGENSEN. (1951) *Acta dermat. venerol., Stockh.*, **31**, 166.

Report of a case of periarteritis nodosa which responded to fever therapy; a colon bacillus vaccine was used. G. A. H.

TREATMENT OF ROSACEA BY MASSAGE. P. SOBYE. (1951) *Acta dermat. venerol., Stockh.*, **31**, 174.

Rosacea is explained as resulting from the action of extrinsic agents, especially climatic, and in certain cases associated with intrinsic agents upon the skin of a predisposed person which cause more or less injury to the small vessels of the face. Subsequent oozing causes the tissue to become stiff and oedematous, and in long-standing cases fibrosis and elephantiasis (rhinophyma) will arise. Four-fifths of his patients responded to facial massage. G. A. H.

ENHANCED ACTION OF COLCHICINE BY THE SIMULTANEOUS USE OF BULBOCAPNINE IN THE TREATMENT OF SKIN CANCER. H. HIRSCH. (1951) *Derm. Wschr.*, **123**, 389.

The author treated a rodent ulcer in one patient and precancerous warts in another with a combination of colchicine and bulbo capnine as a salve and paint. The salve contained colchicine 0.05, bulbo capnine 0.5, vaseline flav. ad 30, and was applied daily with a covering of plaster. Colchicine 0.5-5.0, and bulbo capnine a saturated solution, in 50% alcohol, were painted on one after the other twice weekly as supporting treatment. Both rodent ulcer and precancerous warts which had previously become stationary with colchicine alone improved more rapidly on combining with bulbo capnine. The rodent ulcer healed with a soft scar raised at the border. Some warts also healed with practically no scarring. Others appear to be healing slowly. The author suggests that this treatment may prove useful for cancer elsewhere, e.g., the cervix uteri. There was no biopsy of the healed lesions. M. S. S.

INVESTIGATIONS ON THE REDUCING POWER OF THE SKIN. H. LANGHOR. (1951) *Derm. Wschr.*, **123**, 556.

As a rough index of the reducing power of the skin the author employs the wheal method, injecting intracutaneously sterile methylene blue solution (1:5000 in physiological saline solution pH7) at a temperature of approximately 20°C., raising a wheal 1 cm. in diameter with an anaemic border 2 mm. broad. In 13 controls a wheal on the inner side of the left arm takes an average of 75 minutes to fade. On comparing results simultaneously in circumscribed patches of diseased skin, e.g., psoriasis, and immediately adjacent sound skin an interesting difference in results is obtained.

In psoriasis the patch decolorizes more quickly (e.g., 45 minutes) than the sound skin (e.g., 65 minutes), i.e., has an increased reducing capacity; in vitiligo also. In morphea on the other hand and in furunculosis, ulcers, etc., the wheal takes longer to decolorize, i.e., there is a decreased reducing capacity. In normal controls the skin of the extensor surface of the large joints decolorizes more quickly than the flexor surface, or apocrine areas, e.g., breasts.

The tests are carried out on 68 patients with various complaints and a table of results is given.

The author discusses at length the possible significance of the findings, and points out that remedies used in psoriasis, e.g., ultraviolet light plus eosin lead to oxidation; arsenic, mercury, etc., block the sulphhydryl groups and sensitize the skin to light oxidation. Tar, cignolin, vitamin D, thyroid, etc., exert an oxidizing effect. He wonders among other things if the increased reducing power in the psoriasis skin explains why there is so little tendency to suppuration. Does the sulphhydryl amino-acid cystein play a part in this increased reducing power, and does the histamine-antagonizing action of the reducing substances explain why there is so little tendency to eczema in a psoriatic? He points out that massive doses of vitamin C increase the reducing power of the skin and are beneficial in the treatment of suppuration—where the reducing capacity of the skin is lower than normal.

M. S. S.

IS THE MORBIDITY OF MYCOSIS FUNGOIDES INCREASING? E. BINDER. (1951) *Derm. Wschr.*, **123**, 577.

The author does not believe there is an increased mycosis fungoides morbidity. In the past this has shown fluctuations, and in his opinion earlier diagnosis and the modern greater expectation of life account more probably for the increased number of cases to-day. M. S. S.

CENTRAL NERVOUS SYSTEM DERANGEMENT IN ACRODERMATITIS CONTINUA SUPPURATIVA (HALLOPEAU). Y. LANGHOG. (1951) *Derm. Wschr.*, **123**, 601.

A woman, aged 39, with acrodermatitis continua suppurativa (Hallopeau) suffered from various complaints after an attack of influenza in 1929. This included weakness, irresistible drowsiness, and hyperidrosis of the hands; 12 years later she developed acrodermatitis of fingers, toes, palms, and soles, with exacerbations before menstruation. Many treatments were given, some with effect (during the first three months of a pregnancy the skin cleared spontaneously). With cortidyn, autohaemotherapy and calcium injections there was a remission for 18 months, but treatment had to be stopped owing to shortage of the drugs. Again, with Cortiron crystal implants and Cyren treatment there was a prolonged remission followed by a relapse.

In 1950, among other findings, were increased nervous reflexes, knee- and arm-jerks, absent abdominal reflexes, signs of latent tetany with the blood calcium to the low side of normal, dermatographism, raised C.S.F. sugar, Pandey, opal, etc., i.e., signs of central nervous system derangement. There was a strongly positive reaction to 1:1000 sublimate over the sound skin. With vitamin D₂ therapy, in the form of Vigantol, the patient has improved greatly in the past year, putting on weight and able to work, the lesions healing by scarring. On stopping the vitamin D₂ for more than 2 weeks fresh pustules appear, but it has been possible to reduce the dosage. M. S. S.

MICROSPOROSIS AS A DERMATOLOGICAL PROBLEM. C. SEROWSKY and H. JUNG. (1951) *Derm. Wschr.*, **124**, 665.

The authors in a long article accompanied by very many references discuss the subject of microsporiasis, particularly of the scalp, beginning with its epidemiology and ending with the many methods of treatment, quoting the results of others and giving their own. They find that with modern as with other fungicides weeks or months of treatment are necessary. In addition to the use of a fungicide when treating with x-rays they find manual epilation necessary and carry it out daily. Of 387 children coming under their care the girls required on the average 3 months and 2 days' treatment and the boys a month longer. M. S. S.

XANTHOMATOSIS AND ITS TREATMENT. G. W. KORTING. (1951) *Derm. Wschr.*, **124**, 681.

This article concerns a patient, aged 24, with severe widespread plane, papular and nodular xanthomatosis dating from childhood, and normal total fat and cholesterolin blood serum values. Of particular interest is the well-marked arcus senilis corneae and the excessively high β -globulin blood serum level of 30.5% (normal about 15%); also the intractability to all treatment except finally Inosit 1 g. daily by mouth. With this treatment over a period of two months there is moderate involution and dimming in colour of the lesions. M. S. S.

THE USE OF THE RASP IN COSMETIC PRACTICE. R. LEDIG. (1951) *Derm. Wschr.*, **124**, 713.

The author recommends the dental burr and dental drill machine (with foot switch) giving 3000 revolutions a minute for removing tattoo marks and small naevi, the skin of the area being put on the stretch as far as possible. The machine should attain the requisite revolutions within the first few seconds to allow the operation to be completed within 30 seconds, otherwise oedema and bleeding will mask the field. Diascopy with a glass spatula aids in determining the end-point with tattoo marks. The steel burrs should be carefully washed and dried with a towel and sterilized in hot air, not by boiling. Photographs before and after treatment illustrate the excellent result in extensive tattooing of the forehead and in an extensive systematized warty naevus of the trunk. To obtain a good cosmetic result some epithelial islands and remains of gland-duct openings should escape the rasp and the wound should be dressed with an antiseptic, e.g., boric salve. Melanomata and blue-black naevi should not be treated in this way. M. S. S.

CORPUS LUTEUM HORMONE IN DERMATOLOGY. F. FLECK. (1951) *Derm. Wschr.*, **124**, 717.

The author recommends progesterone for treating pruritus of hormonal origin, e.g., pruritus vulvae with migraine before menstruation, or in the presence of over-production of or sensitivity to oestrogens, or lack of response to oestrogens or androgens. He recommends it particularly in atrophic processes such as pruritus senilis or kraurosis vulvae. It appears to have a calming or peristalsis-inhibiting action on smooth muscle and in hypophysectomized rats aids in the excretion of fluid from the tissues—perhaps these properties contribute to the antipruritic action. A usual dose given intramuscularly is 5 mg. initially followed by 1–5 mg. weekly. Improvement may be noticeable after the second dose, and there may be freedom from symptoms after the fourth. The treatment is given irrespective of the menstrual cycle. As supporting treatment in anogenital pruritus the author uses Castellani's paint. He has had success with progesterone also in the treatment of eczema and asthma. He points out that progesterone has a carcinostatic action.

M. S. S.

UNUSUAL HEALING OF HERPES SIMPLEX WITH LEUCODERMA. M. FLECK. (1951) *Derm. Wschr.*, **124**, 737.

A recurrent herpes involved the right forearm at intervals of from weeks to 2 years over a period of 15 years, sometimes accompanied by severe pain radiating to the axilla and hand. Depigmentation with a flecked hyperpigmented outer zone has been present at the site for a year. Two small depigmented areas the size of a finger-nail are present on the left side of the front of the neck.

M. S. S.

PATHOGENESIS OF DIABETIC VASCULAR DISEASE. G. STÜTTGEN. (1951) *Derm. Wschr.*, **124**, 740.

Vascular derangements in diabetes to be looked for within 10 to 15 years of the onset and lead-for example to increase in permeability are not helped but aggravated by insulin. Comparative experiments suggest that such derangements are due among other factors to the increased reducing power of the blood serum in diabetes as compared with the normal, or liver diseases. This is independent of the blood-sugar level, and may be related to the tissue respiration catalysing flavine system. It is known that ariboflavinosis can develop in diabetes. The increased reducing power in the serum may be influenced by therapeutic measures, and insulin may have the power of increasing the reducing power of the serum without being itself demonstrably reduced. Triphenyltetrazolium chloride is used as the reduction indicator in the author's experiments and biochemical methods used are described.

M. S. S.

SUPRARENAL PREPARATIONS IN PSORIASIS. T. GRÜNEBERG. (1951) *Derm. Wschr.*, **124**, 744.

The author considers that it is possible but not certain that AT10 used by Fleck to treat psoriasis may have a corticotropic effect. Only if the giving of AT10 to experimental animals results in the progressive transformation changes in the cortex described by Tonutti is one justified in regarding it as corticotropic.

M. S. S.

A SIMPLE METHOD OF DISPLAYING THE EPIDERMIS OF HUMAN HAIR. K. BEYERS-DORFER, H. C. FRIEDERICH and H. RUTHER. (1951) *Derm. Wschr.*, **123**, 580.

The author describes a simple method of obtaining a surface impression of human hair on a transparent plastic film using a solution of polystyrol in benzol 1 : 8. The film can then be cut with scissors, leaving the portion of particular interest for microscopical examination. The hair itself becomes absorbed in the process.

M. S. S.

REMARKS ON THE WORK OF SCHEFFLER: "AN ATTEMPT TO EXPLAIN DEATHS FOLLOWING THERAPEUTIC NOVOCAINE INFILTRATION TO INFLUENCE THE VEGETATIVE SYSTEM." K. RAUHUT. (1951) *Derm. Wschr.*, **123**, 581.

The author regrets that Scheffler in his article did not mention his customary dosage of novocaine. He points out that the injection of peripheral nerves is a safe and simple procedure compared with ganglionic infiltration and requires less novocaine, yet the results in dermatology are much the same.

M. S. S.

DEATHS FOLLOWING NOVOCAINE BLOCKADE OF THE SYMPATHETIC CHAIN. W. SCHMITT and H. JUNG. (1951) *Derm. Wschr.*, 123, 582.

The authors refer to Scheffler's article on the above subject and consider he gives too few data. Disagreeing with Scheffler they point out that in the past 15 years over 100,000 sympathetic blocks have been carried out in Germany and abroad (with presumably unexceptional technique), without serious ill effect or death. They cannot agree with Scheffler that deaths are due to circulatory collapse, as any deaths reported in the world literature seem to have followed infection or at least some fault in technique, with intradural escape of the anaesthetic—the higher the level the greater the danger.

M. S. S.

MEGALERYTHEMA EPIDEMICUM (ERYTHEMA INFECTIOSUM). G. W. KORTING. (1951) *Derm. Wschr.*, 124, 785.

Giving very many references the author discusses the history, epidemiology, also the clinical and histological findings of megalerythema epidemicum, which affects female children mainly and is known by many other names, e.g., urticarial German measles, measles without catarrh, etc. He would like to stress that this is a febrile illness as a rule and may accompany other illnesses, e.g., diphtheria, causing confusion. The polymicroadenitis, unlike that in measles, affects mainly the submaxillary region. Unlike measles again the rash lasts 10 to 14 days. After an initial slight leucopenia a leucocytosis develops with almost invariably an eosinophilia. Photographs and microphotographs from one of his patients illustrate the text.

M. S. S.

BEHAVIOUR OF THE THORN REACTION IN SOME SKIN DISEASES WITH PARTICULAR REFERENCE TO THE INVERSE REACTION. L. ADÁM. (1951) *Derm. Wschr.*, 124, 809.

The author describes in detail his technique for the Thorn reaction. Of 35 psoriatics 12 showed a rise of eosinophils after adrenalin (an inverse reaction) and 2 a normal fall. Of 16 erythematodes patients 10 showed a rise and 3 a normal fall. Of the 30 controls (eczema, acne and ulcus cruris) 1 showed a rise and 25 a fall. There was thus sign of adrenal dysfunction in the majority of the psoriasis and erythematodes patients.

M. S. S.

ULIRON THERAPY IN A CASE OF PEMPHIGUS VEGETANS. E. KAUER. (1951) *Derm. Wschr.*, 124, 811.

The author reports a remarkably good result in pemphigus vegetans from uliron, 0.5 g. thrice daily. After four courses and a total of 200 g. in eight months only slight redness and pigmentation remained. The leucocyte count dropped to 2400 during the first course and the uliron had to be stopped after 57.5 g. It dropped to 4300 during the second course after 59.5 g., but with a third (60 g.) and fourth course the leucocyte count remained above 7000. After a pause of 14 to 18 days at the end of the first three courses the skin began to deteriorate, necessitating a further course, but after 37.5 g. the fourth course of uliron was stopped owing to the satisfactory appearances. Ail 1 tablet b.d. was given as supporting treatment, and at times other remedies, e.g., liver, nucleotrat, iron, arsenic.

M. S. S.

LOCAL TREATMENT OF KELOIDS WITH HYALURONIDASE. O. BRAUN-FALCO and G. WEBER. (1951) *Derm. Wschr.*, 124, 796.

The authors treated keloids in three patients with local injections of hyaluronidase (Hoechst) 25–100 units in $\frac{1}{2}$ –1 c.c. of distilled water, daily or every two days (6–12 in all). The injection given with a tuberculin syringe was followed by severe pain and a well-marked local inflammatory reaction. Two responded to treatment with flattening of the keloid and a more normal skin colour, but one failed to respond. A fourth patient with circumscribed scleroderma difficult to inject was given intramuscular hyaluronidase daily without benefit. They consider this treatment might be worthy of use with early keloids.

M. S. S.

TREATMENT OF LUPUS VULGARIS WITH PARA-AMINOSALICYLIC ACID. F. J. EHRLING. (1951) *Derm. Wschr.*, 124, 833.

The author treated 39 patients suffering from lupus vulgaris with PAS locally by salve, wet dressing, injection or ionization, and orally, with little or no benefit. He feels that an effect might be obtained were it possible to obtain a sufficient concentration of drug locally for a sufficient length of time, could a method be devised, for example, to delay absorption. It might be possible to add some substance to the PAS solution for this purpose.

M. S. S.

COLCHICINE TREATMENT OF ERYTHROPLASIA. J. SCHÖNFELD. (1951) *Derm. Wschr.*, 124, 837.

The author treated three cases of genital erythroplasia with colchicine, as a 1 : 2000 salve in one case and as wet dressings 1 to 5 : 1000 several times daily in the others. The surrounding area was protected with zinc paste. One healed after three months and one was almost normal after 25 days. Both remained well. The third, which already showed deeper extension, was a failure. A biopsy confirmed the diagnosis in all cases. With no response to the therapy after 4-5 weeks the treatment should be abandoned. M. S. S.

TREATMENT OF LUPUS ERYTHEMATOSUS. E. THIEL. (1951) *Derm. Wschr.*, 124, 761.

The author has had encouraging results in lupus erythematosus using a combination of four drugs. The treatment is given orally four times daily after food, the four powders being mixed together in powder or tablet form—(1) aurodetoxin 0.0004, (2) quinine hydrochlor. 0.0005, (3) bism. subnitr. 0.005, (4) neo-uliron 0.005—each made up to 0.25 (gramme presumably) with sach. alb. In all, 98 unselected patients were treated; 38 were undoubtedly helped; of the 38, 22 had already been treated, but not so successfully. The simplicity and safety of the remedy recommend it, although adjustment may yet have to be made in the dosage for individual patients. Only three patients showed any untoward effect, in two gastric upset and in one a toxic erythema, which subsided on stopping the treatment. A course consisted of 50 days' uninterrupted treatment, and according to progress was repeated without pause up to 5 times. Improvement was usually noticed first during the second course, becoming more definite in the third or fifth course. A cure consisted in the subsidence of erythema, telangiectasis and scaling. M. S. S.

THE MANAGEMENT OF INFANTILE ECZEMA. I. B. SNEDDON. (1951) *Med. Pr.*, 226, 329.

This article, based on the author's own experience in treating and following these difficult cases throughout the whole of their illness, should be read by all those who undertake the management of infantile eczema. It is probable that these infants have an inborn supersensitivity of the skin and the eczema reaction can be produced by many different factors, such as cold winds, over-vigorous use of soap, a trivial pyoderma, napkin eruption, vaccination, immunization, mild seborrhoeic dermatitis or scabies. Once the process is established, it is kept active by such things as washing, unsuitable topical applications, and the atmosphere of insecurity produced by the natural anxiety of the parents. The allergic factor has been over-emphasized in this condition and diet probably plays very little part.

Success in treatment depends not only on treating the infant, but on an understanding and explanation of the psychological factors which may have existed in the family before the eczema started and which will certainly exist after it has appeared. Sedation either with barbiturates or bromide-chloral mixtures is much more effective in controlling scratching than splinting and wearing restraining garments. In local treatment the keynote of success is to rest the skin as much as possible. Application of an ointment consisting of equal parts emplastrum $\frac{1}{2}$ umbi and vaseline is preferred to starch poultices for removing crusts. Crude coal tar either in shake lotion in the weeping stage or later in Lassar's paste is the main weapon of attack.

Although the great majority of cases recover between the ages of 1 and 2 years, prognosis depends largely on the psychological background of the family. It is also important that when possible the same doctor should treat the case throughout. H. R. V.

REPORT ON 103 CASES OF VARICOSE ULCERATION TREATED WITH SILVER DINAPHTHYLMETHANE DISULPHONATE. S. MCAUSLAND. (1951) *Med. Pr.*, 226, 483.

The author has been in charge of a large varicose ulcer clinic for 23 years. Most of his patients for economic reasons have to be treated as out-patients. His standard technique is to use ichthopaste and elastoplast pressure bandages, but the healing of heavily infected ulcers can be materially hastened by applying twice daily a gauze dressing soaked in a 1% solution of silver dinaphthylmethane disulphonate (viacutan), this covered with a thick pad of cotton-wool, and the whole foot and leg most tightly bandaged with a cotton elastic bandage in which are incorporated a few fibres of live rubber.

After the ulcer has healed, after-care with supporting elastic stockings or bandages is of utmost importance. H. R. V.